

203143

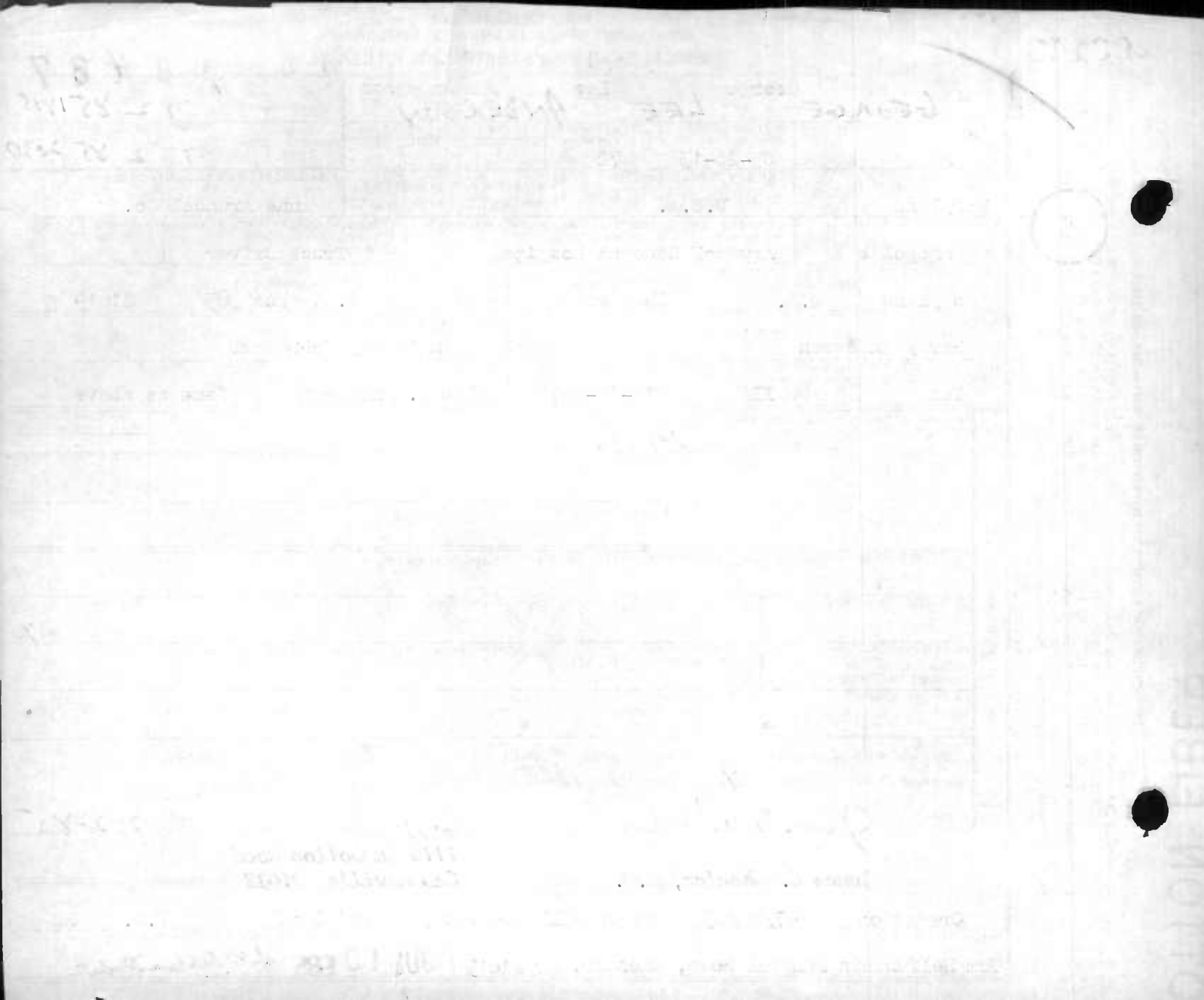
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 18487	
1. DECEASED NAME (TYPE OR PRINT) George Lee Anderson										2a. DATE KNOWN OF DEATH ESTIMATED 7 2 85	
3. SEX M 4. RACE W 5. DATE OF BIRTH 03-26-13 6. AGE (IN YEARS) 72 7. IF UNDER 1 YR. NO 8. IF UNDER 24 HRS. NO										2b. DATE PRONOUNCED DEAD 7 2 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.		
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Arundel General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland 13b. COUNTY Q.A. 13c. CITY OR TOWN Chester 13d. INSIDE CITY LIMITS? YES 13e. STREET ADDRESS Rt. 1 Box 383 21619											
14. FATHER'S NAME Harry Anderson					15. MOTHER'S MAIDEN NAME Annie May Schumaker						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 216-10-2478A		17. INFORMANT Alta H. Anderson			ADDRESS Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) M.I. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? NO		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James S. Wheaton					TITLE (SPECIFY) Dep.			DATE SIGNED 7-2-85			
EXAMINER'S NAME (TYPE OR PRINT) James E. Wheaton, M.D.					ADDRESS 1116 Gumbottom Road						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 07/03/85		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			23d. LOCATION CITY OR TOWN Suitland		COUNTY P.G. STATE MD	
24. FUNERAL DIRECTOR NAME Tom Helfenbein					ADDRESS Funeral Home, Chester, MD 21619			25a. DATE REC'D. BY REGISTRAR JUL 10 1985		25b. REGISTRAR'S SIGNATURE Alta Anderson	



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DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

159088

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 REG. NO. 1 8 4 8 8

1. DECEASED NAME (TYPE OR PRINT) THEODORE			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			7 7 85			2b. HOUR 7 50 P.M.					
3. SEX MALE			4. RACE BLACK			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS			7. IF UNDER 1 YEAR MONTHS DAYS			8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.								
10. CITY OR TOWN OF DEATH ANNAPOLIS			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MARYLAND			13b. COUNTY A.A.			13c. CITY OR TOWN ANNAPOLIS			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 911 E. Royal Street 21401					
14. FATHER'S NAME FIRST MIDDLE LAST ROLAND ANDERSON						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE CHASE											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 42-46			17. INFORMANT Annapolis, Md. 21401			18. MATILDA S. ANDERSON 911 E. Royal Street								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Gastric Carcinoma												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months					
DUE TO, OR AS A CONSEQUENCE OF (b) _____																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																	
DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			21g. DATE SIGNED 7/7/85								
22a. I certify that (I) (this hospital) attended the deceased from 1/10/85 to 7/7/85, that (I) (we) lost saw the deceased only on 7/3/85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) did not view the body after death.																	
22b. SIGNATURE EW Coley						22c. DEGREE MD						22d. DATE SIGNED 7/7/85					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) EW COLEY III						22f. ADDRESS 51 FRANKLIN ST ANNAPOLIS Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 7-12-1985			23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A.A. Maryland								
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.						25a. DATE REC'D. BY REGISTRAR JUL 10 1985			25b. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>								

202159

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DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the physician after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 5 1 8 4 8 9 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST Bessie MIDDLE Gay LAST ANDREWS		2a. DATE OF DEATH / MONTH DAY YEAR		2b. HOUR		15 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 20, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland		13b. COUNTY Queen Anne's		13c. CITY OR TOWN Centreville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE R.D. 2, Box 338, 21617	
14. FATHER'S NAME FIRST MIDDLE LAST William Asa McConkey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie Johnson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-68-7022		17. INFORMANT Daughter		ADDRESS 505 Bay Hills Drive		Mrs. Carol W. Santelmann, Arnold, Md. 21012	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral parvovirus</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/20/55</u> , 19____, to <u>7/2/55</u> , 19____, that (I) (we) last saw the deceased alive on <u>6/20/55</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE <u>S. P. Watkins</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/8/55			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. P. WATKINS		22e. ADDRESS 51 Franklin Street, Annapolis, Md. 21401							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 11, 1985		23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery Centreville, Q.A.Co., Md.		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME James H. Barton, Jr., Centreville, Md. 21617		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					

Female 704

Female White A 11 20, 1911

New Virginia x

Aracelis Anna Arnold General Hospital wife

Aracelis Goodman's Carville x U. S. Box 336 21017

William ASA McDonkey Nellie

815-66-7015 Mrs. James Arnold, Md. 21018

21 17018 West, Aracelis, Md. 21011

James L. Burton, Jr., Carville, Md. 21017
Burton General Hospital
July 11, 1911
Burton General Hospital
Carville, Md. 21017

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 G. NO. 18490

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arthur Edward ASBURY			2a. DATE OF DEATH MONTH DAY YEAR July 9, 1985		2b. HOUR 12:55 P.M.
3. SEX Male	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR Sept. 19, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.		
10. CITY OR TOWN OF DEATH Ft. Meade	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kimbrough Army Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAINTANANCE (ret)		12b. KIND OF BUSINESS OR INDUSTRY FACTORY
13a. STATE Maryland		13b. COUNTY Anne Arundel	13c. CITY OR TOWN Odenton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 525 PATUXANT ROAD 21113
14. FATHER'S NAME FIRST MIDDLE LAST JAMES ASBURY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Millie (UNKNOWN)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	16c. 232-16 - 5892	17. INFORMANT (Son-in-Law) ADDRESS 685 WAUGH CHAPEL RD. MR. TILLMAN L. DENTON ODENTON, MD. 21113		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min.
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic Heart Disease 10 years					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9 July, 19 85, to 9 July, 19 58, that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (not) view the body after death.					
22b. SIGNATURE Joseph Zeligs, LTC, MC, Chief		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9 July 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS Kimbrough Army Community Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE JULY 13, 1985	23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE A.A. MD.	
24. FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME GLEN BURNIE, MD. 21061		25a. DATE RECEIVED BY REGISTRAR JUL 11 1985		25b. REGISTRAR'S SIGNATURE	

BP



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DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

207004

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 NO.

18491

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM L. AVANT			2a. DATE OF DEATH MONTH DAY YEAR JULY 15, 1985			2b. HOUR 0318 PM	
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR April 5, 1924		6 AGE (IN YEARS LAST BIRTHDAY) 61 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina	7b. CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD			
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Vehicle-Maint.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
13a. STATE Maryland		13b. COUNTY Anne Arundel	13c. CITY OR TOWN Pasadena	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Pasadena, Md. 307 Magothy Blvd. / 21122	
14. FATHER'S NAME FIRST MIDDLE LAST WALKER - AVANT			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUCILLE - DEW				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. W.W.11 249-24-2618		17. INFORMANT ADDRESS 307 Magothy Blvd. Mrs. Anna E. Avant / Pasadena, Md. 21122			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency, Severe DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Old Myocardial Infarction, with mural thrombus in the left ventricle. (c) Severe coronary atherosclerosis with total occlusion of the lumen.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE JOSE M. PRESBITERO				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
23a. PHYSICIAN'S NAME JOSE M. PRESBITERO		23b. ADDRESS 7845 OAKWOOD ROAD GLEN BURNIE, MARYLAND 21061					
23c. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23d. DATE July 19, 85		23e. NAME OF CEMETERY OR CREMATORY Glen Haven Mem.Cem.		23f. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, Anne Arundel, Md.	
24. FUNERAL DIRECTOR NAME McCully Funeral Home				25a. DATE REC'D. BY REGISTRAR JUL 22 1985		25b. REGISTRAR'S SIGNATURE Jula Davidson-Randell	

200002

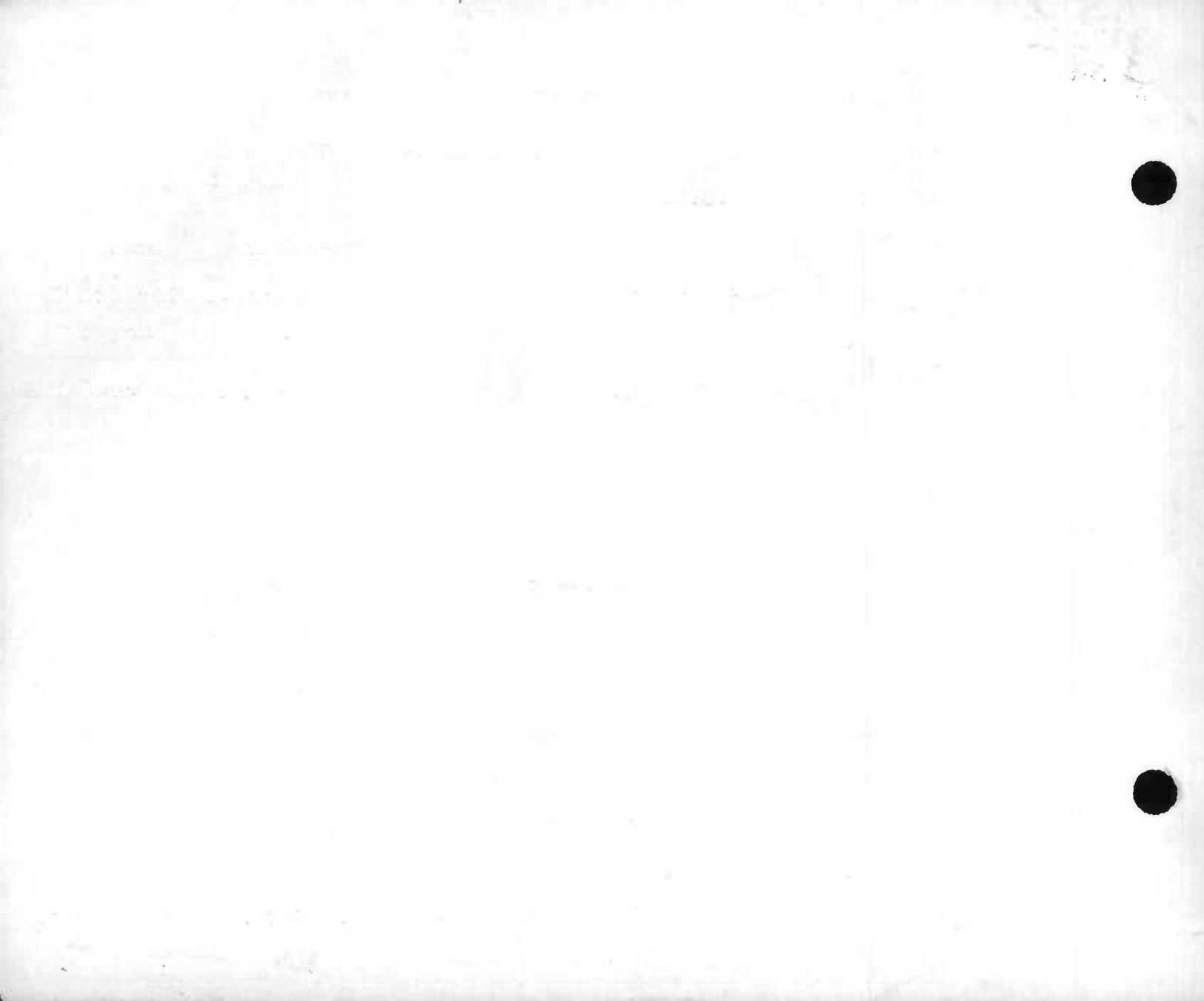
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon #2 and #3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 5 1 8 4 9072	
1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MABELLE LOUISE BAILEY				2a. DATE OF DEATH MONTH DAY YEAR JULY 14, 1985			2b. HOUR AM PM 120 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 28, 1906		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 78			7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland						13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Carson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE Mary E. Cropper					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] NO				16b. SOCIAL SECURITY NO. 220-70-0276		17. INFORMANT ADDRESS Needra Gorman 8048 Forrest Glen Drive 21122					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cardiac hypoxia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. <u>renal failure hypotension</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH [IF EITHER, NOTIFY MEDICAL EXAMINER]				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>85</u> , to <u>7/14</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>7/13</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>James J. Benjamin</u> DEGREE <u>M.D.</u>						22c. DATE SIGNED <u>7/14/85</u>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES J. BENJAMIN, M.D.		
22e. ADDRESS <u>7300 RITCHIE HIGHWAY GLEN BURNIE, MARYLAND 21061</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE July 17, 1985		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Maryland			
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.						25a. DATE REC'D. BY REGISTRAR JUL 16 1985		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 NO. 18493

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Howard E. Baker			2a DATE OF DEATH MONTH DAY YEAR 7 11 85			2b HOUR 10:00P				
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 6 10 23		6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.				
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 602 Wood Street (Home)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b KIND OF BUSINESS OR INDUSTRY Freight		
13a STATE Maryland			13b COUNTY A.A.		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 602 Wood Street 21225	
14 FATHER'S NAME FIRST MIDDLE LAST Wren E. Baker			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Metz							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17 INFORMANT Linda Handschuh		ADDRESS 5315 Wasena Ave Balto Md		21225	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Advanced small cell lung cancer DUE TO, OR AS A CONSEQUENCE OF (c) massive liver metastasis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 14 month		
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from 7-1 , 19 85 , to 7-11 , 19 85 , that (I) (we) last saw the deceased alive on 7-11 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Long S. Hsu			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED July 12-85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Long S. Hsu			22e ADDRESS 7845 Oakwood Rd #205 Glen Burnie Md 21061							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 7/15/85		23c NAME OF CEMETERY OR CREMATORY Glen Haven Mem Park		23d LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md			
24 FUNERAL DIRECTOR NAME ADDRESS George J. Gonce 4001 Ritchie Hwy Balto Md						25a DATE REC'D. BY REGISTRAR JUL 15 1985		25b REGISTRAR'S SIGNATURE Jina Davidson-Rodell		

MEDICAL CERTIFICATION

25 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

26 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

8 5 1 8 4 9 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph E. Barker, Jr.			2a. DATE OF DEATH MONTH DAY YEAR July 3, 1985		2b. HOUR 4:56P M	
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 4, 1922		6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oklahoma	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.		
10 CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Elec. Eng.		12b. KIND OF BUSINESS OR INDUSTRY D.C. Gov't Metro Police	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY A.A.	13c. CITY OR TOWN Edgewater	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph E. Barker, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie L. Bullock				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes-Marines W.W.II		16b. SOCIAL SECURITY NO. 442-14-8907		17 INFORMANT ADDRESS Betty Jo Barker Address Same as No# 13.		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Right Lung Lobes pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Pulmonary Disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a myocardial heart failure, renal failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7/3 19 85 , to 7/3 19 85 , that (I) (we) last saw the deceased alive on 7/3 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death)						
22b. SIGNATURE George P. Samaras		DEGREE MD		22c. DATE SIGNED 7/3/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George P. Samaras		22e. ADDRESS 205 Ridgely Ave Ann. md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 8, 1985		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Oklahoma City Oklahoma Oklahoma		23e. DATE REC'D. BY REGISTRAR JUL 9 1985				
24 FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland		25a. REGISTRAR'S SIGNATURE [Signature]				

1984137

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Prisoner

Number

Name

Address

City

State

County

Occupation

Education

Married

Single

Next of kin

No. 10

400 Riverside Drive 21027

Address same as

Prisoner's name

Prisoner's name

Prisoner's name

Prisoner's name

Prisoner's name

Prisoner's name

Prisoner's name

Prisoner's name

221131

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 REG. NO. 1 8 4 9 5

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Emanuel Barnes</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>7 31 85</i>		2b. HOUR M <i>1</i>
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR <i>1 27 1924</i>		6. AGE (IN YEARS (LAST BIRTHDAY)) <i>61</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE MARYLAND		13b. COUNTY A.A.	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HARRISON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTHEL MITHCELL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (IF YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. 216-18-5056		17. INFORMANT Annapolis, Md. 21401 ELEANOR BARNES 2106 Callahan Lane		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Probable myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>Years</i>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>12/1</i> 19 <i>81</i> , to <i>12/1</i> 19 <i>81</i> , then (I) (we) last saw the deceased alive on <i>12/1</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Gregory Mitchell</i>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8/6/85</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Gregory Mitchell</i>	22e. ADDRESS <i>205 Ridgely Ave Annapolis, Md</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	8-5-1985	PINELAWN MEM. PARK	Annapolis A.A. Maryland
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.		25a. DATE REC'D. BY REGISTRAR AUG 7 1985	
		25b. REGISTRAR'S SIGNATURE <i>William Reese</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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200) 4-2-3

10412-31-250000

WILLIAM L. BROWN & SONS, NEW YORK, N.Y.

207196

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8518496

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Edward L. Bast</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>7/12/85</i>		2b. HOUR M <i>20</i>				
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>07/02/02</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>83</i> YRS.		7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.			
10. CITY OR TOWN OF DEATH <i>ANNAPOLIS</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>ANNE ARUNDEL General Hosp</i>				12a. USUAL OCCUPATION (TYPE AND MOST OF) <i>Marine Construction</i>		12b. KIND OF BUSINESS OR	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>Maryland</i>		13a. COUNTY <i>AA</i>		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE <i>1243 Bast Lane 20764</i>			
14. FATHER'S NAME <i>William F. Bast</i>				15. MOTHER'S MAIDEN NAME <i>Mary Phillips</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OF DATES) <i>111 111 111</i>		17. INFORMANT <i>Raymond Bast</i>		ADDRESS <i>985 Main ST. Galesville Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CHF</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Rheumatoid arthritis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>5 yrs +</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Chronic Rheumatoid arthritis</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>067</i> 19 <i>76</i> to <i>present</i> 19 <i>85</i> , that (I) (we) lost saw the deceased alive on <i>7/12</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.									
22b. SIGNATURE <i>Harvey J. Steinfeld</i>				DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>7/15/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HARVEY J STEINFELD</i>				22e. ADDRESS <i>Shady Side Md 20764</i>					
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		23b. DATE <i>July 16, 1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Woodfield Cem.</i>		23d. LOCATION <i>Galesville AA</i>		STATE <i>Md.</i>	
24. FUNERAL DIRECTOR (NAME AND ADDRESS) <i>John O. Rausch Funeral Home Owings, Md 20736</i>				25a. DATE REC'D. BY REGISTRAR <i>JUL 23 1985</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

20% COTTON-TIBEX

WINTER 1940



207034

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 REG. NO. 18497

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2b. DATE OF DEATH		7b. HOUR	
EDWARD O'NEILL BAXTER		7 21 85		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	8. IF UNDER 1 YEAR	
MALE	WHITE	7 27 1930	55	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
NEW YORK	USA		ANNE ARUNDEL MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Annapolis	AA Gen Hospt.		Executive		Optical Systems
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. STATE	13c. COUNTY	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE	
MD.	AA	ANNAPOHIS		500-A Epping Forest Road 21401	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
Thaddaust	Generieve	NO -			
16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS			
038-18-1633	Christina A Baxter	500-A Epping Forest Rd 21401			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) cardiac arrest					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
H. D. Goldstein		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
H. D. Goldstein		205 Ridgely Ave, Annapolis, MD			
23a. BURIAL, CREMATION, REMOVAL (CHECK)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial	July 25, 1985	St Anne's		Annapolis AA MD	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Taylor Funeral Chapel - Annapolis, MD		JUL 22 1985		[Signature]	

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EDWARD O'NEILL BAKER

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MALE WHITE 4 27 1900

NEW YORK USA X ANNE BRUNDEL

UNBORN AT NEW YORK

MD FA 11/11/11 X 200 11/11/11

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FOR
STATE 8/21/85 rja
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85-18498

1. DECEASED NAME (TYPE OR PRINT) Maurice Beal		2a. DATE OF DEATH MONTH DAY YEAR 7-30-85		2b. HOUR M 1	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8 12 1916		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) Crownsville, MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.		10. CITY OR TOWN OF DEATH Glen Burnie, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plasterer		12b. KIND OF BUSINESS OR INDUSTRY Construction		13a. STREET ADDRESS / ZIP CODE 326 Benfield Road 21146	
13a. STATE Maryland		13b. COUNTY AA		13c. CITY OR TOWN Severna Park	
14. FATHER'S NAME FIRST MIDDLE LAST William Beal		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Augusta Borkman		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	
16b. SOCIAL SECURITY NO. 1941-45		17. INFORMANT Catherine V. Turner, Same as 13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Asthmatic Bronchitis	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert T. Peterson MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/30/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert T. Peterson MD for S. David Krivinas MD		22e. ADDRESS 25 Shaw St Annapolis MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 2, 1985		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD		24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, MD		25a. DATE REC'D. BY REGISTRAR AUG 1 1985	
25b. REGISTRAR'S SIGNATURE [Signature]					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove signature. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

200% COTTON FIBER

MADE IN U.S.A.



159142

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

William

E.

Bell

7a. DATE KNOWN
OF
DEATH MATED☒

MONTH

DAY

YEAR

19

2b. HOUR

M

3. SEX
MALE4. RACE
Cau5. DATE OF BIRTH
April 12, 19166. AGE (IN YEARS)
69 YRS.IF UNDER 1 YR.
MONTHS DAYSIF UNDER 24 HRS.
HOURS MIN.7c. DATE
PRONOUNCED
DEAD

MONTH

DAY

YEAR

19

2d. HOUR

M

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
District
of Columbia

7b. CITIZEN OF WHAT COUNTRY?

U. S. A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

A.A.

MD.

10. CITY OR TOWN OF DEATH

Annapolis

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Anne Arundel Gen. Hospital

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Vice President

12b. KIND OF BUSINESS
OR INDUSTRYConsulting
Firm

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
Md.13b. COUNTY
A.A.13c. CITY OR TOWN
Harwood13d. INSIDE CITY LIMITS?
YES ☐ NO ☒

13e. STREET ADDRESS

1507B Flanders Ln

20776

14. FATHER'S NAME
FIRST

Charles

MIDDLE

William

LAST

Bell

15. MOTHER'S MAIDEN NAME
FIRST

Mary

MIDDLE

Alice

LAST

McMillan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

--

17. INFORMANT

1507-B Flanders Lane,
Patricia A. Bell-Harwood, Md. 2077618. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lastCardio Pulmonary Arrest
ASCVD

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

Diabetes Mellitus

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR

P.M.

19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an

Autopsy ☐Inspection ☒Inquiry ☐

and in my opinion

death resulted from: Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐ACTUAL
SIGNATURE

William P. Jones, M.D.

TITLE (SPECIFY)

M.D. Deputy

MEDICAL EXAMINER

DATE
SIGNED

6 Jul 85

EXAMINER'S NAME
(TYPE OR PRINT)

William P. Jones, M.D.

ADDRESS 695 America Crt., Davidsonville, Md. 21035

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

7/10/85

23c. NAME OF CEMETERY OR CREMATORY

Blue Ridge Cemetery

23d. LOCATION
CITY OR TOWN

Prosperity,

COUNTY

West Virginia

STATE

24. FUNERAL DIRECTOR

Richard A. Coleman Fun'l Home, Upper Marlboro, Md. 20772

25a. DATE REC'D BY REGISTRAR

JUL 08 1985

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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(VR A15 ME (5))

20M 4/82

BP

DMMH - 17
(VR A15 ME (5))

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be attached for use as the burial-transit permit. Then please remove carbon-copy. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRS 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO. 18500

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIDA Wimbrow BENSON			2a. DATE OF DEATH MONTH DAY YEAR 7 25 85		2b. HOUR M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 6 8 1917	6. AGE (IN YEARS LAST BIRTHDAY) 68	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PHILA. P.A.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH AUNE ARUNDEL MD.		
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A.A. GEN. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MARYLAND			13b. COUNTY A.A. Co.	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST REESE WIMBROW			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NINA PORTER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) NO	16b. SOCIAL SECURITY NO. 220261986	17. INFORMANT ADDRESS NAPH. ROY S BENSON #13 Same as			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William A. Dabbs			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-29-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM A. DABBS			22e. ADDRESS 703 GIDDINGS AV. ANNAPOLIS MD.		
23a. BURIAL, CREMATION, REMOVAL (BY) BURIAL	23b. DATE 7/29/85	23c. NAME OF CEMETERY OR CREMATORY U.S. NAVAL ACADEMY	23d. LOCATION OR TOWN ANNAPOLIS A.A. MD.		
24. FUNERAL DIRECTOR NAME TAYLOR FUNERAL CHAPEL			25a. DATE RECEIVED BY REGISTRAR JUL 31 1985		
ADDRESS ANNAPOLIS MD			25b. REGISTRAR SIGNATURE		



VIDA WILSON

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

205004

FOR
STATE
REGISTRAR

86 NO. 18501

1. DECEASED NAME (TYPE OR PRINT) ALICE M BIRCKHEAD			2a. DATE OF DEATH MONTH DAY YEAR 7 19 85		2b. HOUR 5:00		
3. SEX Female		4. RACE Can		5. DATE OF BIRTH MONTH DAY YEAR 6 4 02		6. AGE (IN YEARS LAST BIRTHDAY) 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundle County MD.	
10. CITY OR TOWN OF DEATH Millersville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Knollwood Manor		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. CITY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Authur J. Feathers		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth n/a		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214 44 0218	
17. INFORMANT NAME ADDRESS Lynne Winkler 929 Duvall Hwy 21122							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiopulmonary Arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) **Recent CVA**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Atherosclerosis**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**10 min****1 wk****Years**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **HAP**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION 7/19/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cardiopulmonary Arrest		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —			
22a. I certify that (1) (this hospital) attended the deceased from 7/19/85 to 7/19/85 , that (1) (we) lost saw the deceased alive on 7/19/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE Dr. Schwartz		DEGREE —		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/19/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Schwartz		22e. ADDRESS Oakwood Medical Center					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/22/85		23c. NAME OF CEMETERY OR CREMATORY Balto. National		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland	
24. FUNERAL DIRECTOR NAME Thomas L. Hoban				25a. DATE REC'D. BY REGISTRAR JUL 19 1985		25b. REGISTRAR'S SIGNATURE —	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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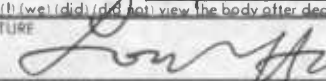
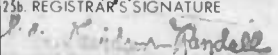
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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 8 5 0 12

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CRAFTON BOONE			2a. DATE OF DEATH MONTH DAY YEAR JULY 18, 1985		2b. HOUR 625 AM				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 1 1915		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POWER Co.		12b. KIND OF BUSINESS OR INDUSTRY RET.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD. 13b COUNTY AA 13c CITY OR TOWN GLEN BURNIE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 611 Mayo Rd. ZIP CODE 21061				
14. FATHER'S NAME FIRST MIDDLE LAST Genflow Boone			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BRANCHE BANKS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WW II 214 050430		17. INFORMANT ADDRESS CATHERINE D. BOONE #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Septic Shock DUE TO, OR AS A CONSEQUENCE OF (c) Pancytopenia, Acute Myelofibrosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CO PD								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days	
								6 days	
								5 month	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-12 , 19 85 , to 7-18 , 19 85 , that (I) (we) last saw the deceased alive on 7-18 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 			DEGREE			22c. DATE SIGNED 7-18-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN S. USUL M.D.			22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 104 GLEN BURNIE, MARYLAND 21061						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 7/20/85		23c. NAME OF CEMETERY OR CREMATORY CEDAR Bluff		23d. LOCATION CITY OR TOWN COUNTY STATE ADWAPACH MD.		
24. FUNERAL DIRECTOR NAME TAYLOR FUNERAL CHAPEL			ADDRESS ADWAPACH, MD.			25a. DATE REC'D. BY REGISTRAR JUL 22 1985		25b. REGISTRAR'S SIGNATURE 	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1- FOR
STATE
REGISTRAR Melba Krauss Brady8 REG. NO. 18503

1. DECEASED NAME (TYPE OR PRINT) <u>Melba</u> <u>K</u> <u>Brady</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>7-2-85</u>		2b. HOUR <u>8:20 PM</u>
3 SEX <u>Female</u>	4 RACE <u>White</u>	5 DATE OF BIRTH MONTH DAY YEAR <u>March 3, 1901</u>	6 AGE (IN YEARS LAST BIRTHDAY) <u>84</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>	7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <u>Anne Arundel County</u> MD.		
10 CITY OR TOWN OF DEATH <u>Annapolis</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Annapolis Convalescent Center</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Clerk</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Fed. Gov't</u>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <u>Maryland</u>	13b COUNTY <u>Anne Arundel</u>	13c CITY OR TOWN <u>Annapolis</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS <u>1065 Norman Drive 21403</u>	
14 FATHER'S NAME FIRST MIDDLE LAST <u>John</u> <u>Krauss</u>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Emma</u> <u>Scherzer</u>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>No</u>		16b SOCIAL SECURITY NO <u>212-03-7375</u>		17 INFORMANT ADDRESS <u>191 St. George Drive</u> <u>Berkeley E. Sadowski Annapolis, MD 21401</u>	

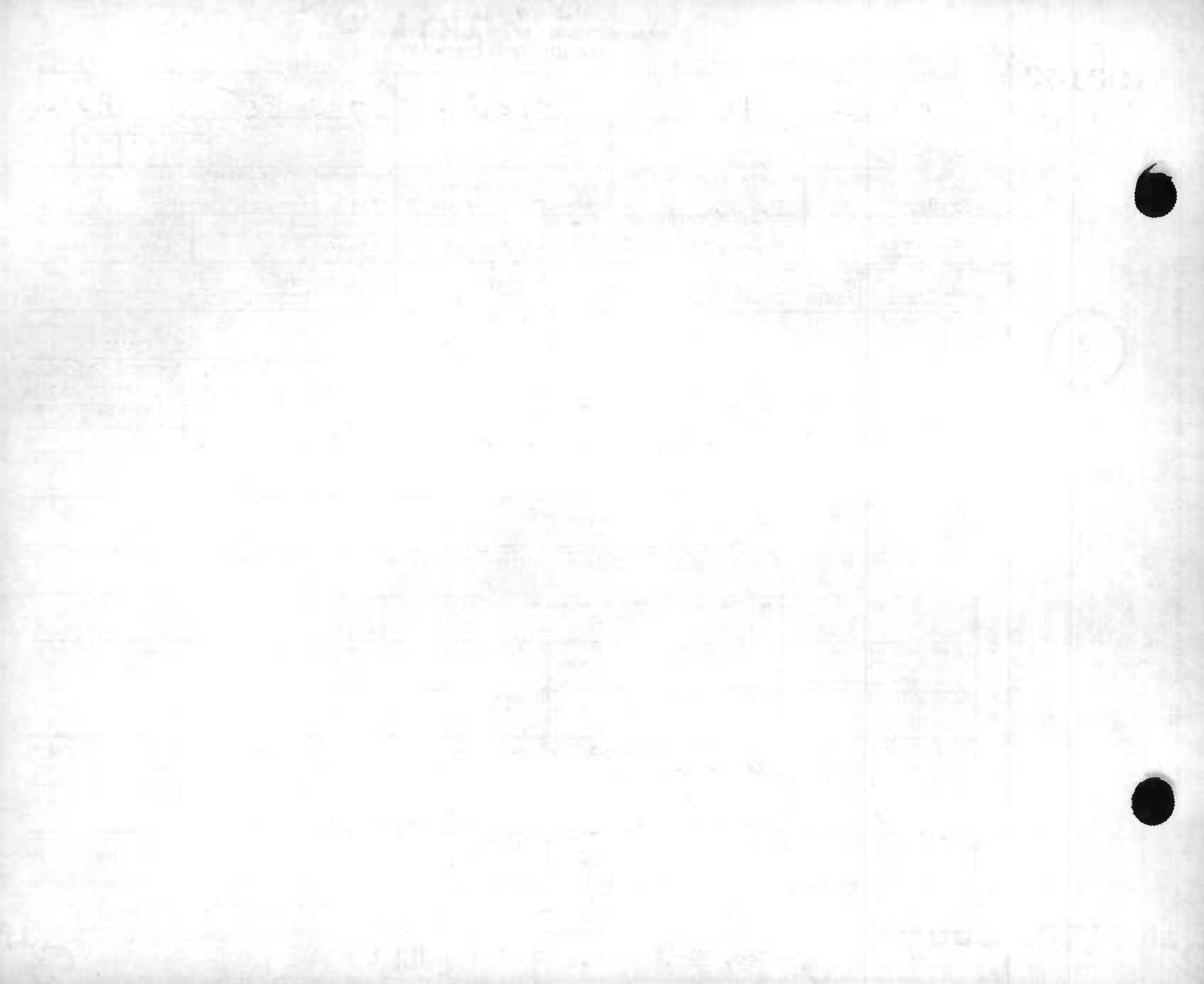
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Breast Carcinoma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) _____		
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that I (this hospital) attended the deceased from <u>5-21-85</u> to <u>7-2-85</u> , that I (we) last saw the deceased alive on <u>6-26-85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.			
22b SIGNATURE <u>[Signature]</u>	DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Walter Brooks Bradley, Inc.</u>		22e ADDRESS <u>Balto., MD 21222</u>	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>	23b DATE <u>7/3/1985</u>	23c NAME OF CEMETERY OR CREMATORY <u>Green Mount Crematory</u>	23d LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore City, Maryland</u>
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24 FUNERAL DIRECTOR NAME <u>Walter Brooks Bradley, Inc. Balto., MD</u>	25 DATE REC'D. BY REGISTRAR <u>JUL 03 1985</u>	25b REGISTRAR'S SIGNATURE <u>[Signature]</u>
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203445

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 5 1 8 5 0 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edwin F. Brask			2a. DATE OF DEATH MONTH DAY YEAR 7-10-85		2b. HOUR MIN. 6:45 AM		
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 5 21 15		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 70	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GEN.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
12b. KIND OF BUSINESS OR INDUSTRY Truck Driver							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Davidsonville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 3056 Davidsonville Road 21035							
14. FATHER'S NAME FIRST MIDDLE LAST John Gustave Braski				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Josephine Mausus			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213-16-2584		17. INFORMANT ADDRESS Alice K. Brask same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Epiglottitis DUE TO, OR AS A CONSEQUENCE OF (b) Di. DUE TO, OR AS A CONSEQUENCE OF (c) Coagulation Disorder CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Coagulation Disorder							
19a. DATE OF OPERATION 7/09/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Tracheostomy		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-9- 19 85 , to 7-10- 19 85 , that (I) (we) last saw the deceased alive on 7-10- 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jack Lichtenstein		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-10-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack Lichtenstein MD		22e. ADDRESS 20 Ridgely Avenue, Annapolis, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 13 1985		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland	
24. FUNERAL DIRECTOR NAME Beall Funeral Home		16000 Annapolis Rd. Bowie, Maryland		25a. DATE REC'D. BY REGISTRAR JUL 16 1985		25b. REGISTRAR'S SIGNATURE John Davidson	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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199041

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 REG. NO. 18505

1. DECEASED NAME (TYPE OR PRINT) Bridges Helen K. K. Bridges		2a. DATE OF DEATH MONTH 7 DAY 9 YEAR 85		2b. HOUR 8:20 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 1 DAY 1 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel County Gen. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home Maker
13a. STATE Maryland	13b. COUNTY A.A.	13c. CITY OR TOWN Pasadena	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST Lewis MIDDLE LAST Buhl		15. MOTHER'S MAIDEN NAME FIRST Henrietta MIDDLE LAST =====		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 212-05-2535	17. INFORMANT ADDRESS Emma Light Rt #3 Box 75B Inman, S.C. 29349		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days 1 month
DUE TO, OR AS A CONSEQUENCE OF (b) Cardiopulmonary arrest		
DUE TO, OR AS A CONSEQUENCE OF (c) COPD		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Cholelithiasis, CHF

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/7 , 19 85 , to 7/9 , 19 85 , that (I) (we) last saw the deceased alive on 7/9 , 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.			
22b. SIGNATURE Joseph N. Friend for Hospital Administrator PHYSICIAN'S NAME (TYPE OR PRINT) Joseph N-Frien		22c. DATE SIGNED 7/9/85	22d. ADDRESS 205 Ridgely Ave Annapolis, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/13/85	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Pk	23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md		25a. DATE REC'D. BY REGISTRAR JUL 12 1985	25b. REGISTRAR'S SIGNATURE John Davidson-Randell

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 5 1 8 5 OEDS
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CECELIA . (nmn) BROCK			2a. DATE OF DEATH MONTH DAY YEAR JULY 11, 1985		2b. HOUR 445 PM					
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 31, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Severn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1148 Thompson Ave. 21144	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Pawelska			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT (Daughter-in-law) Mrs. Dolores J. Brock Same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ASCVD, Hypertension										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from May 19, 1985 to 7/11, 1985 , that (I) (we) lost saw the deceased alive on 7/11/85 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Jose M. Presbitero				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/12/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSE M. PRESBITERO, M. D.				22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 107 GLEN BURNIE, MARYLAND 21061						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE July 12, 1985		23c. NAME OF CEMETERY OR CREMATORY Security Process, Inc.		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balt. Md.				
24. FUNERAL DIRECTOR NAME Abraham ADDRESS				25a. DATE REC'D. BY REGISTRAR JUL 16 1985		25b. REGISTRAR'S SIGNATURE [Signature]				
Singleton Funeral Home Glen Burnie, Md. 21061										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please read and fill in item 21 which should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 85 18507							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nannie B. BRYANT (Nanny)				2a. DATE OF DEATH MONTH DAY YEAR 7 23 85		2b. HOUR 4 ¹³ P.M.			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 6 13 93		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Balt.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT, IN SUCH FACILITY, GIVE STREET ADDRESS) Henderson Hammonds Lane N.C.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Brady				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Melvina Woods					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 402187454		17. INFORMANT ADDRESS Geneva Neutze same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ? Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Seen				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7-24-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SEENIVASA				22e. ADDRESS 606 Hammonds Lane, BALTO, Md, 21228					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-26-85		23c. NAME OF CEMETERY OR CREMATORY Mount Carmel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md			
24. FUNERAL DIRECTOR McCurly Funeral Home				25a. DATE REC'D. BY REGISTRAR JUL 25 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 5 6 1 8 5 0 8
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Melvin Jerry CAREY			2a DATE OF DEATH MONTH DAY YEAR July, 9, 1985		2b. HOUR 7:25 P _M						
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 15, 1924		6. AGE (IN YEARS (LAST BIRTHDAY)) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.					
10 CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 911 Langley Road				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector		12b. KIND OF BUSINESS OR INDUSTRY Kaiser All.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 911 Langley Road 21061			
14 FATHER'S NAME FIRST MIDDLE LAST UNKNOWN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Unknown					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II 219.16.8594		17 INFORMANT ADDRESS Betty J. Smith (daughter) 5 Normandy Dr. Glen Burnie, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ca of lung.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/10</u> , 19 <u>84</u> to <u>7/9</u> , 19 <u>85</u> that (I) (we) lost saw the deceased alive on <u>7/9</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did/did not view the body after death.											
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>7/10/85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Luis M. Zuniga, M.D.				22e. ADDRESS 1101 Maiden Choice Ln., Balto., MD 21229							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE July 12, 1985		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.			
24. FUNERAL DIRECTOR NAME <u>AB V Moore</u> ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
Singleton Funeral Home, Glen Burnie, Md. 21061 JUL 11 1985											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
1. AND 2. TO THE FUNERAL DIRECTOR, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
3. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS
OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 300 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1- STATE REGISTRAR						REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Rebecca E. Claypool						2. DATE KNOWN OF DEATH 7/ 18/ 19 85			
3 SEX Female		4. RACE White		5. DATE OF BIRTH June 25, '61 24 YRS.		6. AGE (IN YEARS) 24 YRS.		7. DATE PRONOUNCED DEAD 7/ 18/ 19 85	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.			
12. CITY OR TOWN OF DEATH Glen Burnie		13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) wooded area near apartment				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Receptionist		15. KIND OF BUSINESS OR INDUSTRY Retail	
16. STATE MD		17. COUNTY A.A.		18. CITY OR TOWN Glen Burnie		19. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. STREET ADDRESS 21061 7892 Americana Cir Apt. 104	
21. FATHER'S NAME FIRST MIDDLE LAST Emmett Flowers				22. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Elizabeth Johnson					
23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				24. SOCIAL SECURITY NO. 261-69-6681		25. INFORMANT Kenneth T. Claypool same as 13			
26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Blunt Force Trauma Head & Neck DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
27. DATE OF OPERATION		28. CONDITION FOR WHICH OPERATION WAS PERFORMED?						29. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
30. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 7/ 18/ 85		32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject beaten					
33. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		34. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) wood area near		35. LOCATION STREET CITY OR TOWN COUNTY STATE 7892 Americana Circle, Glen Burnie, Md.					
36. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
37. ACTUAL SIGNATURE Margarita A. Korell, M.D.				38. TITLE (SPECIFY) Assistant		39. MEDICAL EXAMINER		40. DATE SIGNED 7/19/85	
41. EXAMINER'S NAME (TYPE OR PRINT)		42. ADDRESS 111 Penn St.							
43. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		44. DATE 22 July 85		45. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		46. LOCATION CITY OR TOWN COUNTY STATE Dorsey Howard MD			
47. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley Glen Burnie MD				48. DATE REC'D. BY REGISTRAR JUL 22 1985		49. REGISTRAR'S SIGNATURE Davidson-Randall			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-2837.

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(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO. 1851 ED	
1. DECEASED NAME (TYPE OR PRINT) GEORGE NORMAN COOPER		2a. DATE OF DEATH MONTH DAY YEAR JULY 20, 1985	
3. SEX MALE		2b. HOUR 1007 PM	
4. RACE WHITE		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	
5. DATE OF BIRTH MONTH DAY YEAR OCT. 18, 1903		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
7b. CITIZEN OF WHAT COUNTRY? U.S.A.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR	
10. CITY OR TOWN OF DEATH GLEN BURNIE		12b. KIND OF BUSINESS OR INDUSTRY BOX CO.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		13a. STREET ADDRESS 1415 EVERGREEN RD. 21144	
13a. STATE MD		13b. COUNTY A.A.	
13c. CITY OR TOWN SEVERN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE D. COOPER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES MIRAH WRIGHT	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212.03.4327	
16c. NONE		17. INFORMANT (WIFE) ADDRESS DORA M. COOPER SAME AS #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Charles J. Wu</i>		22c. DATE SIGNED July 21, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES J. WU M.D.		22e. ADDRESS 7845 OAKWOOD RD #204 GLEN BURNIE MD 21061	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JULY 24, 1985	
23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM. PK		23d. LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE A.A. MD.	
24. FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR JUL 23 1985	
ADDRESS GLEN BURNIE, MD. 21061		25b. REGISTRAR'S SIGNATURE <i>Janae M. Davidson</i>	

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHREG. NO. 8 5 1 8 5 1 1
2a. DATE OF DEATH MONTH DAY YEAR 7 27 85
2b. HOUR am 3:00 (M)

1. DECEASED NAME (TYPE OR PRINT) FIRST Donald MIDDLE C. LAST Corrigan <i>DONALD CORRIGAN</i>		2a. DATE OF DEATH MONTH DAY YEAR 7 27 85		2b. HOUR am 3:00 (M)
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4-26-1912		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.
10. CITY OR TOWN OF DEATH Gambrills	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1266 - Lavall Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (Ret.) Lt. D.C. Fire Dept.	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Brentwood	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4505 - 37th Street (20722)
14. FATHER'S NAME FIRST MIDDLE LAST Michael Corrigan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marguerite Wright			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-07-1642	17. INFORMANT Margaret K. Rightnour Gambrills, Md.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MEURINOMA</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a-

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>7/26/85</i> , 19____, to <i>7/27/85</i> , 19____, that (I) (we) last saw the deceased alive on <i>7/26/85</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>John R. H. H. H.</i>		DEGREE		22c. DATE SIGNED 7/29/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-31-1985	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Geo. Md.
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc. Mt. Rainier, Md.		25a. DATE REC'D. BY REGISTRAR AUG 1 1985	25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Two please return carbon papers, pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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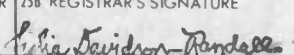
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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DHMH - 17
(VR A15 ME (5))

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	8 5 1 2				
1. FOR STATE REGISTRAR										7					
1. DECEASED NAME (TYPE OR PRINT) Adam T. Courtright										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7 23 1985				2b. HOUR 2:23A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 30 69		6. AGE (IN YEARS) LAST BIRTHDAY 15 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD 7 23 1985		2d. HOUR 2:23A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD			
10. CITY OR TOWN OF DEATH Glen Burnie				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student				12b. KIND OF BUSINESS OR INDUSTRY =====			
13a. STATE Maryland				13b. COUNTY A.A.		13c. CITY OR TOWN Harmons		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS P.O. Box 11 21077					
14. FATHER'S NAME FIRST MIDDLE LAST Harold Daniel Courtright					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dolores Courthouse King										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No					16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Dolores M. King Same as 13e								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound wound of head</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):															
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:30xx 7 23 1985					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house					21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7528 Cranberry Court, Hanover, A.A.Co, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> .															
ACTUAL SIGNATURE 					TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER					DATE SIGNED 7/23/85					
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.					ADDRESS 111 Penn St. Balto, MD.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 7/24/85		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Balto A.A. Md					
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hgwy Balto Md										25a. DATE REC'D. BY REGISTRAR JUL 24 1985		25b. REGISTRAR'S SIGNATURE 			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without delay after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal investigation is required to be notified to the

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

8 5 1 8 5 1 3
REG. NO. 18513

1. DECEASED NAME (TYPE OR PRINT) LOTTIE L CRAWFORD			2a. DATE OF DEATH MONTH DAY YEAR JULY 05, 1985		2b. HOUR 1150AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 7, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator	12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE Maryland		13b. COUNTY Anne Arundel	13c. CITY OR TOWN Severn	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Lentz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Janowska			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-28-0766	17. INFORMANT ADDRESS Edward R. Crawford 763 Donaldson Ave. 21144			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ca of colon, metastatic</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>bowel obstruction 2° Ca of colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/5/85</u> 19 <u>85</u> to <u>7/5</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>7/5/85</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/5/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES J. BENJAMIN, M.D.		22e. ADDRESS 653 OLD MILL ROAD MILLERSVILLE, MARYLAND 21108			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/9 May 85	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.	23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. MD.		
24. FUNERAL DIRECTOR NAME ADDRESS Kirkley F.H. Glen Burnie MD.		25a. DATE REC'D. BY REGISTRAR JUL 9 1985	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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NOTICE

MINIATURE



ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11-11-81 BY SP-1

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGES 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))
20M 4/82

1-
OR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 5 1 4

1. DECEASED NAME (TYPE OR PRINT) Alain (ALAN) Roger Crowley		2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> 7 14 1985		2b. HOUR 1
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> Jan. 3, 1940	6. AGE (IN YEARS) LAST BIRTHDAY <input checked="" type="checkbox"/> 45 YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vermont		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel		10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Emp.		12b. KIND OF BUSINESS OR INDUSTRY Consultant		
13a. STATE Maryland		13b. COUNTY Anne Arundel	13c. CITY OR TOWN Millersville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
13e. STREET ADDRESS 890 Cecil Ave.		13f. CITY OR TOWN Avon 21108		
14. FATHER'S NAME FIRST William MIDDLE J. LAST Crowley		15. MOTHER'S MAIDEN NAME FIRST Gertrude MIDDLE R. LAST Kennedy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 106-30-9597		17. INFORMANT (Wife) ADDRESS Mrs. Ivia W. Crowley # 13
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ASCUD DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. Hypertension				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE William P. Jones		TITLE (SPECIFY) M.D. Deputy		DATE SIGNED 7/14/85
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.		ADDRESS 695 America Court Davidsonville, Md. 21035		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE July 15, 1985	23c. NAME OF CEMETERY OR CREMATORY Security Process, Inc.		23d. LOCATION CITY OR TOWN Catonsville COUNTY Baltimore STATE Md.
24. FUNERAL DIRECTOR NAME R. G. Hopkins		25a. DATE REC'D. BY REGISTRAR JUL 16 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall
26. FUNERAL HOME Singleton Funeral Home, Glen Burnie, Md.				

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH85 18515
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John E. Cunningham			2a. DATE OF DEATH MONTH DAY YEAR 7-2-85		2b. HOUR M
3. SEX male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11-12-19	6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co., MD.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Foreign Service Officer
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY A.A. 13c. CITY OR TOWN Annapolis			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 2516 Lyon Drive 21403		
14. FATHER'S NAME FIRST MIDDLE LAST John Cunningham			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Friel		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1941-1950 267-12-9284			17. INFORMANT ADDRESS Betty F. Cunningham - Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Smallcell Carcinoma to Liver DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) obstructive Jaundice.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:30 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 6/30 19 85 to 7/2 19 85 , that (1) we saw the deceased alive on 7/1 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we (did) (did not) view the body after death.					
22b. SIGNATURE George P. Samaras		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/2/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George P. Samaras		22e. ADDRESS 205 Ridgely Ave Ann. MD 21401			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE July 5, 1985		23c. NAME OF CEMETERY OR CREMATORY Rock Creek	
23d. LOCATION CITY OR TOWN COUNTY STATE Washington DC		24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel-Annapolis, MD			
25a. DATE REC'D. BY REGISTRAR JUL 03 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8518516
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edwin W. Danielson			2a. DATE OF DEATH MONTH DAY YEAR July 6, 1985		2b. HOUR 2:00 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 5 1900	6. AGE (IN YEARS LAST BIRTHDAY) 84	7. UNDER 1 YEAR MONTHS DAYS 8. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.		
10. CITY OR TOWN OF DEATH Edgewater	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant Living Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Paint Formulator	12b. KIND OF BUSINESS OR INDUSTRY State of Tenn.	
13a. STATE Md.		13b. COUNTY AA Co	13c. CITY OR TOWN Crownsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1303 Eva Gude St. 21032
14. FATHER'S NAME FIRST MIDDLE LAST John Danielson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Paulson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 146-01-0277		17. INFORMANT Mabel Danielson Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>stroke</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic brain syndrome</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>chronic brain syndrome</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>about</u> 19 <u>80</u> , to <u>7-6</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>above</u> (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>G.M. Mitchell MD</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7-8-85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>G.M. Mitchell MD</u>		22e. ADDRESS <u>805 Ridgeley Ave Annapolis Md</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE <u>7/10/85</u>	23c. NAME OF CEMETERY OR CREMATORY Hermitage Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hermitage Tenn.
24. FUNERAL DIRECTOR NAME Hardesty Futral Home			ADDRESS Annapolis, Md.		25a. DATE REC'D. BY REGISTRAR JUL 08 1985
					25b. REGISTRAR'S SIGNATURE <u>W. Danielson</u>

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C. 1500

213101

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 5 1 8 5 1 7
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Leslie Darwell			2a. DATE OF DEATH MONTH DAY YEAR July 25 1985			2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1-26-1913		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Services		12b. KIND OF BUSINESS OR INDUSTRY US Gov.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY AA Co.		13c. CITY OR TOWN Edgewater		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 900 Fairview Dr. 21037	
14. FATHER'S NAME FIRST MIDDLE LAST James Darwell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth UNK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT Virginia M. Darwell		ADDRESS Same as #13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanotic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 19 69</u> to <u>Jul 25 85</u> , that (I) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>Charles W. Kinzer</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-26-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles W Kinzer				22e. ADDRESS 16 MURRAY Ave Annapolis MD 21401			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-29-85		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Breetwood PGCo. Md.	
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home				ADDRESS Annapolis, Md.		25a. DATE REC'D. BY REGISTRAR JUL 30 1985	
25b. REGISTRAR'S SIGNATURE <u>Greta Davidson-Randall</u>							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

101618



213073

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		3. SEX		4. RACE		5. DATE OF BIRTH	
THOMAS JEFFERSON DAVIDSON SR.		JULY 27, 1985		Male		White		JAN. 27, 1925	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
TENNESSEE		U.S.A.				ANNE ARUNDEL COUNTY MD.		TRUCK DRIVER	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE		13b. INSIDE CITY LIMITS?	
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		TRUCKING		1746 CIRCLE ROAD 21146		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
MD		A.A.		SEVERN		WILLIAM T. DAVIDSON		EVO LENA LARKINS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (SISTER)		ADDRESS		1306 GILL ST.	
YES		210.34.1002		BLANCHE L. FAUDREE		ODENTON, MD.		21113	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>MI</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/9/85</u> 19 to <u>7/27/85</u> 19, that (I) (we) last saw the deceased alive on <u>about one month</u> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED					
Jorge B. Ramirez, M.D.		7845 OAKWOOD ROAD GLEN BURNIE, MARYLAND 21061		7/27/85					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN COUNTY STATE)			
BURIAL		JULY 30, 1985		GLEN HAVEN MEM. PARK		GLEN BURNIE A.A. MD.			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
SINGLETON FUNERAL HOME GLEN BURNIE, MD. 21061		JUL 30 1985		[Signature]					

BP

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COLORED COTTON



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218133

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 18519

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Paul</u> MIDDLE <u>Levan</u> LAST <u>DANKINS</u> <u>Paul L. Dawkins</u>			2a. DATE OF DEATH MONTH <u>7</u> DAY <u>27</u> YEAR <u>85</u>		2b. HOUR <u>4:40P</u> M.		
3. SEX <u>MALE</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>Jan. 19, 1922</u> <u>01 19 22</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>63</u> YRS MONTHS <u>03</u> DAYS <u>19</u> HOURS <u>22</u> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Anne Arundel</u> MD.	
10. CITY OR TOWN OF DEATH <u>Annapolis</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Anne Arundel General Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK OR SERVICE) <u>Equipment Opr. (ret.)</u>		12b. KIND OF BUSINESS OR <u>Maintenance Tree Expert</u>	
13a. STATE <u>Maryland</u>				13b. COUNTY <u>Queen Anne's</u>		13c. CITY OR TOWN <u>Centreville</u>	
14. FATHER'S NAME FIRST <u>John</u> MIDDLE <u>Jennings</u> LAST <u>Dawkins</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Nora</u> MIDDLE <u>Vashti</u> LAST <u>Sommers</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>		16b. SOCIAL SECURITY NO. <u>WW II 215-16-8093</u>		17. INFORMANT <u>Wife</u> ADDRESS <u>R.D. 2, Box 229</u> <u>Mrs. Ruth A. Dawkins, Centreville, Md. 21617</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Small cell carcinoma of lung.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 mos.</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (ENT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/27/85</u> to <u>7/27/85</u> , that (I) (we) last saw the deceased alive on <u>7/27/85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Richard Peeler</u>				22c. DATE SIGNED <u>7/27/85</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Richard Peeler, M.D.</u>	
22e. ADDRESS <u>Annapolis, Md. 21401</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>July 30, 1985</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Centreville, Q.A.Co., Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Barton Funeral Home</u> ADDRESS <u>James H. Barton, Jr., Centreville, Md. 21617</u>				25a. DATE REC'D. BY REGISTRAR <u>AUG 02 1985</u>			
				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified.

1943

SEP 19 1943

Analysis

Analysis

Analysis



SEP 19 1943

SEP 19 1943

James H. Barton, Jr., Knoxville, Tenn. 1943
Winton - General Name
July 30, 1943
Knoxville, Tenn. 1943

213071

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8518520

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) William E. Deckert			2a. DATE OF DEATH MONTH DAY YEAR July 26, 1985			2b. HOUR 9:30 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 20, 1931		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none	
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 502 Stanhome Dr. 21061		14. FATHER'S NAME FIRST MIDDLE LAST Julius Deckert					
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Schmeitz		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no					
16b. SOCIAL SECURITY NO. 216-74-2132		17. INFORMANT ADDRESS Jane Spann same as 13					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congenital Heart Disease</u>		<u>all life</u>	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Down's Syndrome</u>		<u>all life</u>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <u>Kidney Failure</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/28</u> 19 <u>85</u> , to <u>July 26</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>July 15</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <u>not</u> alter death.			
22b. SIGNATURE <u>Joseph Taler M.D.</u>		22c. DATE SIGNED <u>July 29, 1985</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Taler M.D.		22e. ADDRESS 95 Aquahart Rd. Glen Burnie MD.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 29 July 85		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD	
24. FUNERAL DIRECTOR NAME James S. Kirkley Glen Burnie MD				25a. DATE REC'D. BY REGISTRAR JUL 30 1985			
25b. REGISTRAR'S SIGNATURE <u>John T. ...</u>							

204026

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

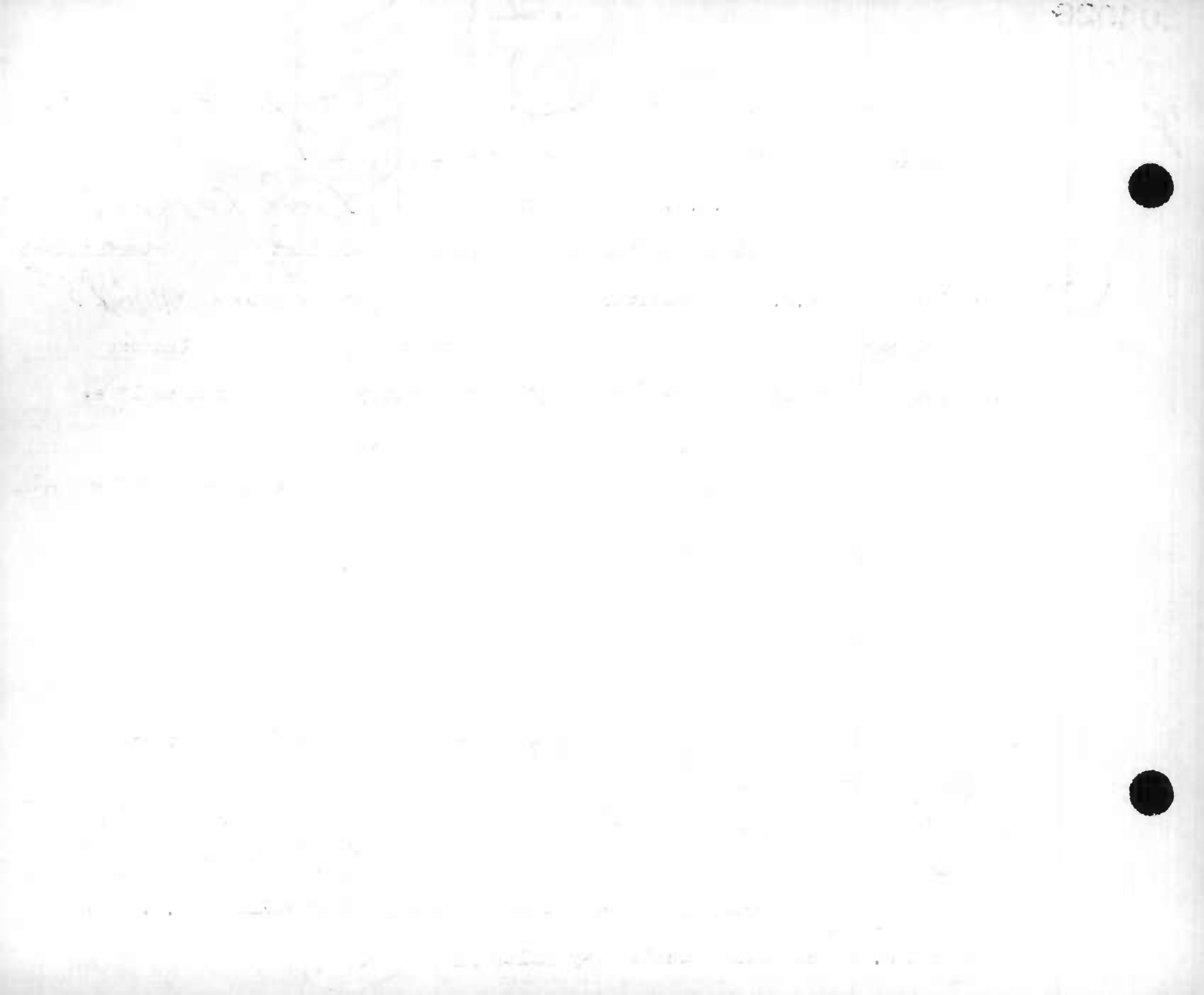
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 REG. NO. 18521

1. DECEASED NAME (TYPE OR PRINT) ELMER E. DENNIS			2a. DATE OF DEATH MONTH DAY YEAR 7-16-85		2b. HOUR 3:04 AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 8 30 23	6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH DWIGHT BRUNDT MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 501 Cedar Hill Road (Home)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Vocalist	12b. KIND OF BUSINESS OR INDUSTRY Entertainment	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY A.A.	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Unknown Unknown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown Unknown Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 007-16-7778		17. INFORMANT ADDRESS Grace Murphy Same as 13 e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR ARREST DUE TO, OR AS A CONSEQUENCE OF (b) NON CAT CIVIL LUNG CANCER DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7/5/85 19 85 , to 7/16 19 85 , that (I) (we) last saw the deceased alive on 7/15/85 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Donothy Snow MD		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/16/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donothy Snow MD		22e. ADDRESS 3900 Loch Raven Blvd BALTO, MD. 21212			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/18/85	23c. NAME OF CEMETERY OR CREMATORY Md Veterans Cemetery		23d. LOCATION Crownsville	23e. COUNTY A.A. STATE Md
24. FUNERAL DIRECTOR George J. Gonce		25a. DATE REC'D. BY REGISTRAR JUL 17 1985		25b. REGISTRAR'S SIGNATURE Davidson-Randall	

BP



202096

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85G. NO. 1852012

1. DECEASED NAME (TYPE OR PRINT) ETHEL LEE DIX			2a. DATE OF DEATH MONTH DAY YEAR JULY 10, 1985		2b. HOUR 815 PM
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Feb. 17, 1909	6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST Noah J. Boyce			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Lou Poland		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 236 36 1456		17. INFORMANT ADDRESS Mr. Julian Bosley Pasadena, Md. 21122	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC STANDSTILL					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE					
DUE TO, OR AS A CONSEQUENCE OF (c) R					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: RESPIRATORY FAILURE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6 30 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 203 E. PATAPSCO AVENUE BALTIMORE, MARYLAND 21225	
22a. I certify that (I) (this hospital) attended the deceased from 6/30 , 19 85 , to 7/10 , 19 85 , that (I) (we) lost saw the deceased alive on 7/10 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE S. MINDRA		DEGREE MD		22c. DATE SIGNED 7/11/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SIRYA P. MINDRA, M.D.		22e. ADDRESS BALTIMORE, MARYLAND 21225			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/15/85	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem.		23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey, Maryland	
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME, INC.		ADDRESS 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR JUL 12 1985	
				25b. REGISTRAR'S SIGNATURE J. A. Burdon-Randall	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried with the deceased within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



207031

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies; Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as on page 1.

1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 5 REG. NO. 1 8 5 2 3	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARTHUR E. DODD		2a. DATE OF DEATH MONTH DAY YEAR 7 18 85		2b. HOUR 1 A. M.	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 4 - 17 - 1908		6. AGE (IN YEARS LAST BIRTHDAY) 77	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNAPOLIS MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A. H. GYEN HOSPT.		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. CITY OR TOWN ANNAPOLIS		13c. STREET ADDRESS / ZIP CODE 2 ROMAR DR 21403	
14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL DODD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE MC NICHOLAS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 1169-05-8870		17. INFORMANT ADDRESS JEANNETTE DODD Same as # 13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia.		DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral aspiration pneumonia		DUE TO, OR AS A CONSEQUENCE OF (c)	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pruritic Ca					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6 12 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS MD	
22a. I certify that (1) this hospital attended the deceased from 7/17/85 to 7/18/85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.					
22b. SIGNATURE My Ch...		DEGREE		22c. DATE SIGNED 7/18/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George C. Samaras		22e. ADDRESS 205 Ridgely Ave Annapolis, MD		22f. REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE July 20, 1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff	
23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS MD		23e. DATE REC'D. BY REGISTRAR JUL 22 1985		23f. REGISTRAR'S SIGNATURE R. E. ...	

7

1-12-1943
J. E. DODD
4-17-1943
FINE HENDEL
KIMMERS HILTON HOTEL
NO. 141
MICHAEL DODD
12-15-1943
J. E. DODD

12-15-1943
J. E. DODD
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J. E. DODD

BP _____

DHMM - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 23 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

200017

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 18524

1. DECEASED NAME (PRINT) Regina G. Downey			2a. DATE OF DEATH MONTH DAY YEAR JULY 7, 1985		2b. HOUR 5:45 AM
1. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JUNE 14, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH HARWOOD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4201 SANDS ROAD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POSTAL SERVICE	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES E. DOWNEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH G. VOSS		16. SOCIAL SECURITY NO. 216-44-9226	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		17. INFORMANT NIECE MICHELLE SMITH		ADDRESS 3930 CALAWASSE ROAD EDGEWATER, MD. 21037	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) stroke DUE TO, OR AS A CONSEQUENCE OF (c) atrial fibrillation APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 2, 1985 , to July 7, 1985 , that (I) (we) last saw the deceased alive on July 2, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Julie Buchanan		DEGREE M.D.		22c. DATE SIGNED 7-7-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Julie Buchanan		22e. ADDRESS 6131 Shady Side Rd, Shady Side MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/10/85		23c. NAME OF CEMETERY OR CREMATORY OLD ST. JOHNS	
23d. LOCATION CITY OR TOWN COUNTY STATE FOREST GLEN MONT MD.		23e. DATE REC'D. BY REGISTRAR JUL 11 1985			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		24b. ADDRESS 500 UNIV. BLVD. (W.) SILVER SPRING, MD. 20901			

MEDICAL CERTIFICATION

Downey



214012

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 NO. 1 8 5 2 5

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST L. B. EDWARDS			2a. DATE OF DEATH MONTH DAY YEAR 7-29-85		2b. HOUR 6¹⁰ AM				
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 01-27-1922		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland			13c. CITY OR TOWN Stevensville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE P. O. Box 103 21666	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Lyda Edwards			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jeneva Hill			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES Yes WWII			
16b. SOCIAL SECURITY NO. 246-14-1781			17. INFORMANT Jerry M. Edwards, Rt. 3			ADDRESS Maryland 21666 Box 61, Stevensville			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (EAT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from Sept 83 19____, to 8/29/85 19____, that (I) (we) lost the deceased alive on 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not visit the body after death.									
22a. SIGNATURE Greg E. Hulst			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED 7/29/85	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) GLIMMER			22e. ADDRESS 801 Melvin Ave Annapolis						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 08-02-85		23c. NAME OF CEMETERY OR CREMATORY Aquone Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Aquone Macon N.C.		
24. FUNERAL DIRECTOR NAME ADDRESS Tom Helfenbein Funeral Home, Chester, MD 21619					25a. DATE REC'D. BY REGISTRAR JUL 31 1985		25b. REGISTRAR'S SIGNATURE John B. Anderson		

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

510125

12-15-4

12-15-4

12-15-4

12-15-4



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 NO. 1852EDT6

1- FOR STATE REGISTRAR		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
RUDOLPH JOHN EISENZOPF SR		JULY 5, 1985		700 AM	
1 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	
Male	White	Dec. 28, 1911	73 YRS.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		ANNE ARUNDEL COUNTY MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF LIFE)	12b KIND OF BUSINESS OR INDUSTRY	
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		Sheet Metal Worker	Local #100	
13a STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Anne Arundel	Glen Burnie	13e STREET ADDRESS / ZIP CODE 21061	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Robert Eisenzopf, Sr.		Minnie Reich		No	
16b SOCIAL SECURITY NO.		17 INFORMANT (Son)		ADDRESS 123 Glendale Ave.	
213-05-5650		Mr. Rudolph J. Eisenzopf, Jr.		Glen Burnie, Md 21061	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Metastatic Carcinoma of Lung to Liver					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		P.M. 19			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from July 1, 1985, to July 5, 1985, that (I) (we) last saw the deceased alive on July 4, 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.					
22b SIGNATURE		DEGREE		22c DATE SIGNED	
CHARLES J. WU, M.D.				July 5, 1985	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		22f. DATE REC'D. BY REGISTRAR	
		7845 OAKWOOD ROAD, SUITE 204 GLEN BURNIE, MARYLAND 21061		JUL 05 1985	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
Burial		July 8, 1985		Glen Haven Mem. Pk.	
24 FUNERAL DIRECTOR NAME		24b DATE		24c LOCATION CITY OR TOWN COUNTY STATE	
R. A. Hopkins		July 8, 1985		Glen Burnie A.A. Maryland	
Singleton Funeral Home, Glen Burnie, Md.		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
		JUL 05 1985			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM RW-2, BEING FILED 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMITS. PAGES 1 AND 2 SHOULD BE FILED (WITHIN 72 HOURS AFTER DEATH), WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8527

1. DECEASED NAME (TYPE OR PRINT) Gerard		2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR ESTIMATED <input type="checkbox"/> 7 2 1985		2b. HOUR M				
3. SEX M	4. RACE CAU	5. DATE OF BIRTH MONTH DAY YEAR Sept 8 1913	6. AGE (IN YEARS) LAST BIRTHDAY 71 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 2 1985	7d. HOUR 0000	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.		
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GEN. HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Priest		12b. KIND OF BUSINESS OR INDUSTRY Religion		
13a. STATE md		13b. COUNTY AA		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21401 109 Duke of Gloucester
14. FATHER'S NAME FIRST MIDDLE LAST Ferdinand Ellinghaus		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna E. Bielein		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. —		17. INFORMANT St. Marys Church ADDRESS 109 Gloucester St. Annapolis MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. A.S.C.U.D. (b) — DUE TO, OR AS A CONSEQUENCE OF (c) —								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion								
ACTUAL SIGNATURE William P. Jones, M.D.		TITLE (SPECIFY) Deputy M.D. MEDICAL EXAMINER				DATE SIGNED 7/2/85		
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.		ADDRESS 695 America Court, Davidsonville, Md. 21035						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 5, 1985		23c. NAME OF CEMETERY OR CREMATORY Redemptorist Gen		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD		
24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel-Annapolis MD				25a. DATE REC'D BY REGISTRAR JUL 03 1985		25b. REGISTRAR'S SIGNATURE W. J. Davidson-Randall		

OFFICE OF THE ATTORNEY GENERAL
STATE OF TEXAS

Wm. H. ...
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207127

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8518528

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RONALD L. FABER			2a. DATE OF DEATH MONTH DAY YEAR 7-18-85		2b. HOUR 11:00 AM
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 3 20 15		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS 0 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CANADA	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GEN. HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER	12b. KIND OF BUSINESS OR INDUSTRY MANE. SALES REP.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS FABER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOROTHY SWALES		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 136-09-5524		17. INFORMANT DERIS M. FABER ADDRESS (SAME AS 13)	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Rectal Cancer DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 months
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7/12 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 51 FRANKLIN ANNAPOLIS MD.	
22a. I certify that (1) this hospital attended the deceased from 7/12 85 to 7/18 85 that (1) (we) last saw the deceased alive on 7/18 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (2) we (did) (did not) view the body after death.					
22b. SIGNATURE E W Cole III		DEGREE MD		22c. DATE SIGNED 7/18/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E W COLE III		22e. ADDRESS 51 FRANKLIN ANNAPOLIS MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE JULY 22, 1985	23c. NAME OF CEMETERY OR CREMATORY RESTLAND CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE UNIVERS MORRIS NJ	
24. FUNERAL DIRECTOR NAME BARRANCO FUNERAL HOME		501 RITCHIE HWY. SEVERNA PARK, MD		25a. DATE REC'D. BY REGISTRAR JUL 22 1985	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove completed pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH85 18529
REG. NO. 1852EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VINCENT FEDERICI			2a. DATE OF DEATH MONTH DAY YEAR JUNE 23, 1985		2b. HOUR 0922 AM		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 27, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Paymaster Corp.	
13a. STATE Md.		13b. CITY OR TOWN Glen Burnie		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 317 Oak Manor Dr. Apt. 201	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Federici		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie V. Raconiello					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2 155-07-4040		17. INFORMANT ADDRESS Carolyn. Federici, Wife, same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Recent myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic liver disease + New Improved.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/23/85 19 85 , to 6/23/85 19 85 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DALJIT S. SAWHNEY M.D.		22c. DATE SIGNED 6/23/85		22d. PHYSICIAN'S NAME (TYPE OR PRINT) DALJIT S. SAWHNEY M.D.			
22e. ADDRESS 7422 BALTIMORE-ANNAPOLIS BOULEVARD GLEN BURNIE, MARYLAND 21061							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 26 June 85		23c. NAME OF CEMETERY OR CREMATORY St. Josephs Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Swedesboro, Gloucester, N.J.	
24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, Md.				25a. DATE REC'D. BY REGISTRAR JUN 24 1985		25b. REGISTRAR'S SIGNATURE Gelia Davidson-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called in.

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CLINICAL RECORDS

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 18530

1. DECEASED NAME (TYPE OR PRINT) ELEANOR FICKES			2a. DATE OF DEATH MONTH DAY YEAR 7-13-85			2b. HOUR 11:55 AM			
3. SEX F		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4-27-13		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. UNDER 1 YEAR MONTHS DAYS 72	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Brooklyn A.A. MD.			
10. CITY OR TOWN OF DEATH Brooklyn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hammonds Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales		12b. KIND OF BUSINESS OR INDUSTRY Food Service	
13a. STATE Maryland			13b. COUNTY N		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST George Burkett			15. MOTHER'S MAIDEN NAME MIDDLE LAST Mabel Dively			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16a. SOCIAL SECURITY NO. 220-24-4604			17. INFORMANT ADDRESS George E. Fickes, Jr. 1221 Glen Haven Rd. Balto. Md. 21239			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) hypotension DUE TO, OR AS A CONSEQUENCE OF (b) gastrointestinal bleeding DUE TO, OR AS A CONSEQUENCE OF (c) widespread (metastatic) breast carcinoma PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from March 12 1985 to July 13 1985 , that (1) (we) last saw the deceased alive on July 13 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40) (41) (42) (43) (44) (45) (46) (47) (48) (49) (50) (51) (52) (53) (54) (55) (56) (57) (58) (59) (60) (61) (62) (63) (64) (65) (66) (67) (68) (69) (70) (71) (72) (73) (74) (75) (76) (77) (78) (79) (80) (81) (82) (83) (84) (85) (86) (87) (88) (89) (90) (91) (92) (93) (94) (95) (96) (97) (98) (99) (100) (101) (102) (103) (104) (105) (106) (107) (108) (109) (110) (111) (112) (113) (114) (115) (116) (117) (118) (119) (120) (121) (122) (123) (124) (125) (126) (127) (128) (129) (130) (131) (132) (133) (134) (135) (136) (137) (138) (139) (140) (141) (142) 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Handwritten text in the middle section, possibly a title or heading, including the words "Investigation" and "Report".

Handwritten notes and stamps at the bottom of the page, including a date stamp "JUL 13 1952" and various illegible markings.

193039

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1- FOR REGISTRAR RICHARD EDMUND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8531

1. DECEASED NAME (TYPE OR PRINT) Richard Edmund Fischer										2. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 19 7-1-85		2b. HOUR M 1500					
3. SEX Male		4. RACE CAU		5. DATE OF BIRTH MONTH DAY YEAR 11-16-33		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 51		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 19 7-1-85		2d. HOUR M 1500			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) E. Orange, N.J.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH A.A. Rundel Co. MD.					
10. CITY OR TOWN OF DEATH Ft. Meade				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kimbrough Army Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Computer Programmer				12b. KIND OF BUSINESS Security					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 21207 7140 Fairbrook Road			
13a. STATE Md.		13b. CITY Baltimore		13c. CITY OR TOWN Woodlawn		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Miskela				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 29 Aug 56 144-26-711		17. INFORMANT ADDRESS Ethel McClernan Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE William P. Jones, MD				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 7/2/85					
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.				ADDRESS 695 America Crt. Davidsonville, Md. 21035													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7/8/85				23c. NAME OF CEMETERY OR CREMATORY Restland Memorial Park				23d. LOCATION CITY OR TOWN COUNTY STATE East Hanover Essex New Jersey					
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228																	
25a. DATE REC'D. BY REGISTRAR JUL 08 1985																	
25b. REGISTRAR'S SIGNATURE Richard Edmund Fischer																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE REASON FOR DELAY IN ITEM 18. THIS CERTIFICATE, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH THE DEATH CERTIFICATE, PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGE 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

12/2/57

12/2/57

AM

Richard E. Brown

12/2/57

12/2/57

12/2/57

X

12/2/57

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1 - FOR
STATE
REGISTRAR

8 REG. NO.

1 8 5 3 2

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Harriet F. Fonda</i>			7a. DATE OF DEATH MONTH DAY YEAR <i>07 18 1985</i>		7b. HOUR <i>8 a.m.</i>					
3. SEX <i>Female</i>		4. RACE <i>Caucas.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 30 05</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <i>80</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i>IF UNDER 24 HRS.</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.				
10. CITY OR TOWN OF DEATH <i>Severna Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Meridian-Severna Park</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Treasurer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Chemical Co.</i>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>			13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Severna Park</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>80 Riverside Dr Severna Park 21146</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Edgar Frost</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Hyde</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>213-03-5300</i>		17. INFORMANT ADDRESS <i>John Hall 68 Riverside Dr. Severna Park</i>						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>ARTERIO SCLEROSIS, GENERALIZED</i>			
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.
(1) Pulmonary Fibrosis (2) Possible Pulmonary Embolus, Probly due to Rt. hip Fr.

19a. DATE OF OPERATION <i>7-1-85</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Rt. subcapital fracture Rt hip</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 15</i> , 19 <i>57</i> , to <i>July 18</i> , 19 <i>85</i> , that (I) (we) lost saw the deceased alive on <i>7-16</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
27b. SIGNATURE <i>Thomas J. Codd</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c. DATE SIGNED <i>7-18-85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>THOMAS J. CODD</i>				22e. ADDRESS <i>PO Box 627 SEVERNA PK Md 21146</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		23b. DATE <i>7/18/85</i>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <i>Anatomy Board</i>				ADDRESS <i>Balto., Md.</i>		25a. DATE RECEIVED BY REGISTRAR <i>JUL 24 1985</i>	
				25b. REGISTRAR'S SIGNATURE <i>John Gordon-Fordell</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SECRET

2102



SECRET

SECRET



204013

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH85 REG. NO. 185 JDT3
2a DATE OF DEATH MONTH DAY YEAR 2b HOUR PM
JULY 13, 1985 545 PM

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA MARIE FONTZ		2a DATE OF DEATH MONTH DAY YEAR JULY 13, 1985		2b HOUR PM 545 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 13 1904	
7a BIRTHPLACE (STATE OR FOREIGN) Balt. Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
10 CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE ADDRESS) NORTH ARUNDEL HOSPITAL		9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
12a USUAL OCCUPATION (IF IN BUSINESS, INDUSTRY, OR SERVICE) Clerical work		12b. KIND OF BUSINESS OR INDUSTRY Tasco Import		13a STREET ADDRESS / ZIP CODE 7957 Sunshine Court AptC 21061	
14 FATHER'S NAME FIRST MIDDLE LAST William Gibson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Louise Stecker		13b. COUNTY Anne Arundel	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS Mrs. Dorothy E. Rose same as #13 Daughter	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u>			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CEREBRO VASCULAR ACCIDENT</u>			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CONTRIBUTING TO DEATH</u>			
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7-7-85</u> to <u>7-13-85</u> that (I) (we) last saw the deceased alive on <u>7-13-85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Chackumkal V. Cyriac</u>		22c. DATE SIGNED <u>7/15/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHACKUMKAL V. CYRIAC, M. D.		22e. ADDRESS 14 WELLHAM AVENUE, SUITE 101 GLEN BURNIE, MARYLAND 21061	

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE July 17, 1985		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland	
24 FUNERAL DIRECTOR NAME Singleton Funeral Home #1 Second Ave 21061				25a. DATE REC'D. BY REGISTRAR JUL 16 1985		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

S.W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it can and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20-2012-000

DATE: JULY 13, 1995 PAGE: 1

JAMES MICHAEL GUNNY

CLIN BUREAU NORTH AMERICAN HOSPITAL



CLIN BUREAU, NORTHERN AVENUE, SUITE 101
CHICAGO, ILL. 60611

JUL 13 1995

192038

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO. 1 8 5 3 4

1. DECEASED NAME (TYPE OR PRINT) James Albert Gardner			2a. DATE OF DEATH MONTH DAY YEAR 7 9 85		2b. HOUR 6:20 PM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 6- 9 03	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.		
10. CITY OR TOWN OF DEATH Crownsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairfield Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pressman	12b. KIND OF BUSINESS OR INDUSTRY Newspaper		
13a. STATE Delaware		13b. CITY OR TOWN Sussex Millsboro	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS Route 6 Box 71 19966	

14. FATHER'S NAME FIRST MIDDLE LAST Elda Gardner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mima Benton	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-01-1761	17. INFORMANT Dorothy Broglie	
		ADDRESS 855 Mill Creek Road Arnold, Md. 21012	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S.C.U.D.</u>		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Cerebrovascular Accident, Gastric Ulcer Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8 Dec</u> , 19 <u>83</u> , to <u>9 July</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>3 July</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>William P. Jones, MD.</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William P. Jones, MD.		22e. ADDRESS 2444 Old Solomons Island Road	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-13-85	23c. NAME OF CEMETERY OR CREMATORY Loudon Park	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR McGully Funeral Home		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 8 JUL 15 1985	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, page 4 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

BP

DHMH - 16 25M

VR A 15 (4) 19 74

213074

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG 5 1 8 5 EOT 5

1. DECEASED NAME (TYPE OR PRINT) MATILDA Bayne GILES			2a. DATE OF DEATH MONTH DAY YEAR JULY 27, 1985		2b. HOUR 1030 AM
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR July 5, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) sales clerk	12b. KIND OF BUSINESS OR INDUSTRY Lee's Pharm.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY AA 13c. CITY OR TOWN Glen Burnie			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. ADDRESS 410 Pamela Rd. 21061	
14. FATHER'S NAME FIRST MIDDLE LAST Mathias S. Melson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Scott			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) xxxxxxx 216/12/9387	17. INFORMANT ADDRESS Glen Burnie, MD Wayne G. Turner (grandson)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Pulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Renal Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 18					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7-12-1985 to 7-27-1985 that (I) (we) lost saw the deceased alive on 7-27-1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <i>Chackumkal V. Cyriac</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-28-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHACKUMKAL V CYRIAC, M.D.		22e. ADDRESS 14 WELLHAM AVENUE, SUITE 101 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 30 July 1985	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD	
24. FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie, MD		25a. DATE REC'D. BY REGISTRAR JUL 30 1985		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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2013/03/07

RECEIVED

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189096

1- FOR
STATE
REGISTRAR MILDRED GLOVERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHREG. NO. 18536
2a. DATE OF DEATH MONTH 7 DAY 1 YEAR 85 2b. HOUR 945 P.M.1. DECEASED NAME FIRST MIDDLE LAST
Mildred (MILLIE) Glover

3. SEX

FEMALE

4. RACE

WHITE

5. DATE OF BIRTH

10-21-1894

6. AGE (IN YEARS LAST BIRTHDAY)

90

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?

U.S.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Anne Arundel Co. MD.

10. CITY OR TOWN OF DEATH

Glen Burnie

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

North Arundel Conv. Home

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Homemaker

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. CITY

A.A.

13c. CITY OR TOWN

Woodlawn Hgts.

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

1104 Rosedale Ave. (21061)

14. FATHER'S NAME

FIRST

Evan

MIDDLE

Jones

LAST

15. MOTHER'S MAIDEN NAME

FIRST

Ellen

MIDDLE

Phillips

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

160 50 7295

17. INFORMANT

ADDRESS

Ruth Glover (same as 13e)

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

COPD

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) CHF, HASCVD

DUE TO, OR AS A CONSEQUENCE OF

(c) Diabetes Mellitus

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

arteriosclerosis

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)

21f. LOCATION STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 1980 to 7-1-85, that (I) (we) last saw the deceased alive on 7-1-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

7-1-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

7/5/1985

23c. NAME OF CEMETERY OR CREMATORY

Odd Fellows Cemetery (21225)

23d. LOCATION CITY OR TOWN

Tamaqua, Pennsylvania

COUNTY

STATE

24. FUNERAL DIRECTOR

George J. Gonce, 4001 Ritchie Hg., Baltimore, MD.

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

JUL 02 1985

Eileen Davidson-Randell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

BP

100000

(100000)

(100000)

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X

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100000

214037

Items 18-22a 9/16 mth F#607

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

2. DATE KNOWN OF
DEATH ESTI-
MATED ☐ 7 23 19 85

3. SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS
LAST BIRTHDAY)

IF UNDER 24 YRS.

IF UNDER 24 HRS.

2c. DATE
PRONOUNCED
DEAD

MONTH DAY YEAR

2d. HOUR

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)12b. KIND OF BUSINESS
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. CITY OR TOWN

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

13e. STREET ADDRESS

14. FATHER'S NAME

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 7/23/ 19 85

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

home

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

652 Charante Ct. Glen Burnie, A. A. Co.

22a. I certify that I took charge of the remains described above, held on

Autopsy ☒Inspection ☐Inquiry ☐

and in my opinion

death resulted from:

Natural causes ☐Accident ☐Suicide ☒Homicide ☐Undetermined manner ☐ACTUAL
SIGNATURETITLE (SPECIFY)
M.D. Assistant

MEDICAL EXAMINER

DATE SIGNED 7/23/85

EXAMINER'S NAME
(TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS 111 Penn St. Balto.MD.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION
CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Taylor Funeral Chapel - Annapolis, MD

JUL 31 1985

A. A. M.D.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25MDHMH - 17
(VR A15 ME (5))

214098

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN FENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. A COPY OF THIS FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8532

1. DECEASED NAME (TYPE OR PRINT) Carol Bernadine Gray			2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 19 7 25 85			2d. HOUR 2130		
3. SEX Female	4. RACE CAU	5. DATE OF BIRTH MONTH DAY YEAR 10 28 21 63	6. AGE (IN YEARS) LAST BIRTHDAY 22	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 7 25 19 85		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH AA		
10. CITY OR TOWN OF DEATH Severna Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 414 RIGGS AVE 21146			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MD.		13b. COUNTY AA	13c. CITY OR TOWN Severna Park	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 414 Riggs Ave 21146			
14. FATHER'S NAME FIRST MIDDLE LAST PLOEGER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adele Berg					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 492/12/1184		17. INFORMANT ADDRESS Melvin Gray (Same as #13)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF A.S.C.U.D. Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE William P. Jones, M.D.			TITLE (SPECIFY) DEPUTY			DATE SIGNED 2/24/85		
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.			ADDRESS 695 America Ct., Davidsonville, Md. 21035					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 7-27-85		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD		
24. FUNERAL DIRECTOR NAME Robert Barranco ADDRESS 495 Ritchie Hwy MD 21146			25a. DATE REC'D. BY REGISTRAR JUL 30 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

800413

①

215

ON TOP OF SIDE

WIND

10

WIND

159143

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 12 hours after death. Page 4 may be retained by the hospital or attending physician.

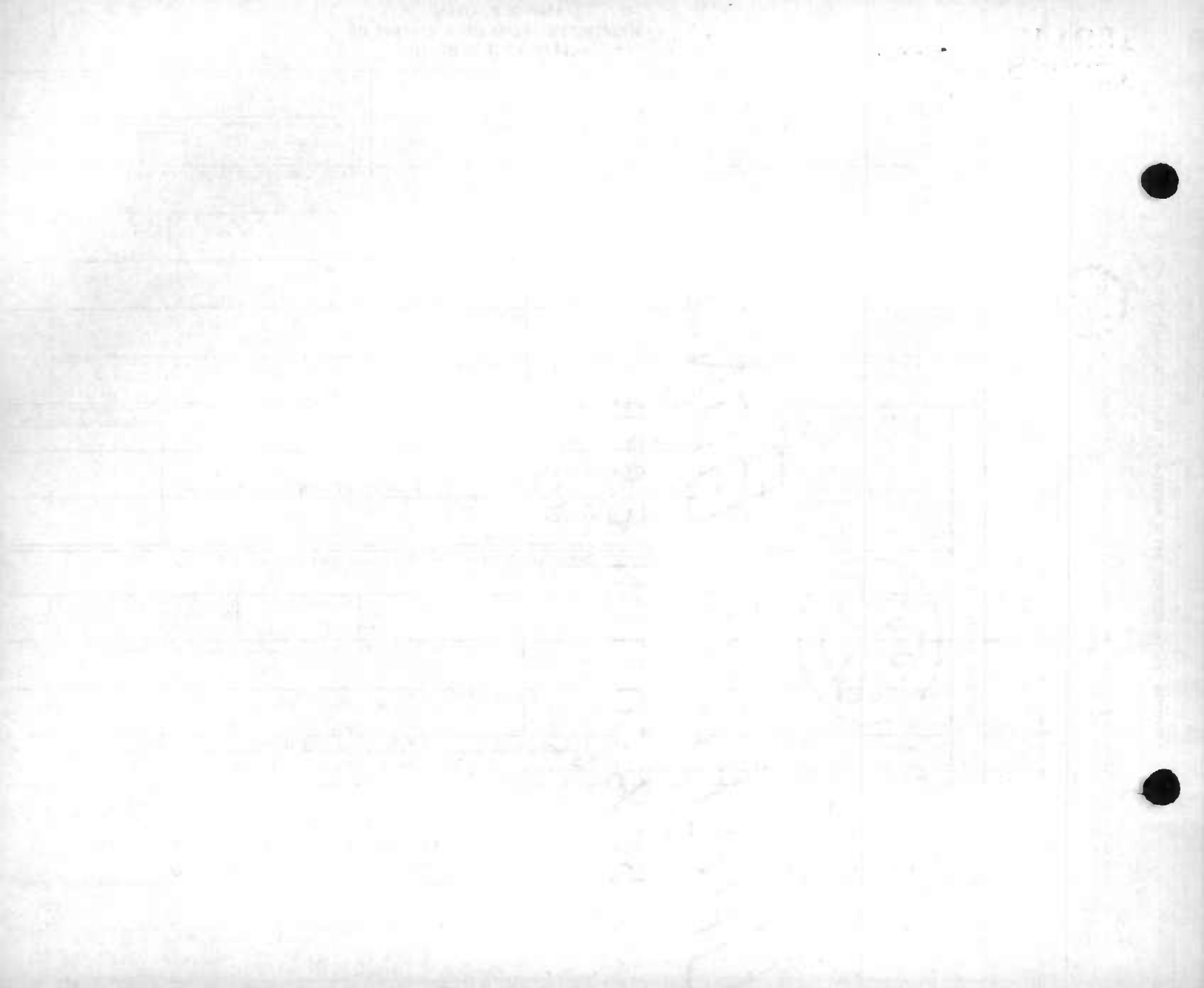
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 REG. NO. 18539

1. DECEASED NAME (TYPE OR PRINT) GRIESER		FIRST Caroline	MIDDLE CAROLINE	LAST Grieser	2a. DATE OF DEATH MONTH DAY YEAR July 5, 1985		2b. HOUR 5:30a	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 20, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 91		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.		
10. CITY OR TOWN OF DEATH Edgewater		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant Living Conv. Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Md		13b. COUNTY AA		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 312 4th Ave. S.W.
14. FATHER'S NAME FIRST MIDDLE LAST Carl Fukun				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Russ				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-24-2037A		17. INFORMANT Donald Grieser				ADDRESS Edgewater, Md. 21037
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Infected, nonhealing bilateral stumps (surgical amputations) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from March 1985 to JUNE 1985 , that (1) (we) lost saw the deceased alive on 6-21 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Elizabeth Anne Spitzer MD				DEGREE MD		22c. DATE SIGNED 7-5-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Elizabeth Anne Spitzer				22e. ADDRESS 19 Chesapeake Beach Road, East Owings, Md. 20736				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8 July 85		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, AA, Md.		
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, Md.				ADDRESS 		25a. DATE REC'D. BY REGISTRAR JUL 9 1985		25b. REGISTRAR'S SIGNATURE



150099

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) JOHN GRIFFIN					2. DATE KNOWN OF DEATH MONTH 7 DAY 7 YEAR 1985 HOUR ?				
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH 9 DAY 8 YEAR 01	6. AGE (IN YEARS) LAST BIRTHDAY 83 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7c. DATE PRONOUNCED DEAD MONTH 7 DAY 9 YEAR 85	2d. HOUR 1330		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED XX DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH LOTHIAN		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5184 Sands Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN LOTHIAN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5184 Sands Rd. 20711	
14. FATHER'S NAME FIRST CHARLES MIDDLE GRiffin LAST GRiffin				15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE WATERS LAST WATERS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO.		17. INFORMANT Washington, D.C. 20001 JOHN E. GRIFFIN 424 A Warner St. N.W.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus (probable) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) - Deep Thrombophlebitis - both legs DUE TO, OR AS A CONSEQUENCE OF (c) - Aortic Aneurysm APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE J. E. Wheeler				TITLE (SPECIFY) Dep		MEDICAL EXAMINER		DATE SIGNED 7-9-85	
EXAMINER'S NAME (TYPE OR PRINT) James E. Wheeler, M.D.				ADDRESS 1116 Gumbottom Road Crownsville 21032					
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 7-12-1985		23c. NAME OF CEMETERY OR CREMATORY MOSES CEMETERY		23d. LOCATION CITY OR TOWN Drury COUNTY A.A. STATE Maryland			
24. FUNERAL DIRECTOR NAME Annapolis, Md. 21401 WILLIAM REESE & SONS MORTUARY, P.A.						25a. DATE REC'D. BY REGISTRAR JUL 10 1985		25b. REGISTRAR'S SIGNATURE <i>Davidson</i>	

• 301 2000 1012

10028 70C, normal data
10029 70C, normal data

57420 • J. Neurosci., September 24, 2008 • 28(39):5739–5748

803094

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 REG. NO. 18541

1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)		2a DATE OF DEATH		2b HOUR	
		John Wilbur Gunter Sr.		7 12 85		8:00	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
Male		Caucasian		9 28 11		73	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
S. Carolina		U.S.A.				Anne Arundel County MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Pasadena		7835 E. Shore Road 21122		Car Inspector		Railroad	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		A.A.		Pasadena		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.	
John Wesley Gunter		Louise Whittington		No		250-18-7301	
17 INFORMANT		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer Tongue</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____		19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
Pasadena, Maryland 21122		19c. DATE OF OPERATION		19d. TIME OF INJURY		20a AUTOPSY?	
Julia Gunter 7835 E. Shore Road						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY	
		YES <input type="checkbox"/> NO <input type="checkbox"/>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED	
				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
				21g. CITY OR TOWN		21h. COUNTY	
				21i. STATE		21j. DATE SIGNED	
				21k. SIGNATURE		21l. DATE SIGNED	
				21m. PHYSICIAN'S NAME (TYPE OR PRINT)		21n. ADDRESS	
				CORNEZIA M. DETTMER		1277 GREEN HOLLY DR. ANNAPOLIS, MD 21401	
				22a BURIAL, CREMATION, REMOVAL (SPECIFY)		22b DATE	
				Cremation		7-15-85	
				22c NAME OF CEMETERY OR CREMATORY		22d LOCATION	
				Westview Crematory		Catonsville Balto. Md.	
				22e FUNERAL DIRECTOR		22f. DATE REC'D. BY REGISTRAR	
				Raymond C. Fink Glen Burnie, Md. 21061		JUL 12 1985	
				22g. REGISTRAR'S SIGNATURE		Julia Gunter	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[illegible]

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8518542

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST James M. Hagood		2a. DATE OF DEATH MONTH DAY YEAR 7-9-85		2b. HOUR 1:50 PM	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 11-01-26		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Service Station		12b. KIND OF BUSINESS OR INDUSTRY Self-emp.	
13a. STATE Md.		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 103 Shiley St. 21401		14. FATHER'S NAME FIRST MIDDLE LAST William Kile Hagwood		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Allie Mae Frazier			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 220-16-7872		17. INFORMANT ADDRESS Wesley O. Hagood 10 Alder Rd. Ann. Md. 21403			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMA OF ESOPHAGUS</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DIABETES MELLITUS</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7 July 1985</u> to <u>9 July 1985</u> , that I (we) last saw the deceased alive on <u>9 July 1985</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did not view the body after death.							
22b. SIGNATURE <u>Edward S. Beck MD</u>				22c. DATE SIGNED 7-9-85		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward S. Beck MD				22e. ADDRESS 1616 Forest Dr. Annapolis Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/10/85		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Ann. Md.	
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home				25a. DATE REC'D. BY REGISTRAR JUL 12 1985			
ADDRESS 12 Ridgely Ave. Ann. Md. 21401				25b. REGISTRAR'S SIGNATURE <u>Jake Davidson-Rendell</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



207030

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REC NO. 18543

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Thelma W Hall</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>7 17 85</i>		2b. HOUR <i>1A</i> M
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>May 3, 1907</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel Co.</i> MD.	
10. CITY OR TOWN OF DEATH <i>Annapolis</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1 St. Mary's Street</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Secretary Executive</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>MD</i>	13b. COUNTY <i>A.A.</i>	13c. CITY OR TOWN <i>Annapolis</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>1 St. Mary's Street 21401</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Mathew Thomas Moody</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ellen P. Pafford</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>577-20-6525</i>		17. INFORMANT <i>Alfred B Weirich 9208 Rangley Drive Houston, Texas 77055</i>	

18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac Arrest.

DUE TO, OR AS A CONSEQUENCE OF

(b)

Atherosclerosis -

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (1) (this hospital) attended the deceased from <i>7/1</i> to <i>7/17</i> 19 <i>85</i> that (1) (we) last saw the deceased alive on <i>6/10</i> 19 <i>85</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did not) view the body after death.			
22a. SIGNATURE <i>Rodney L. Brimball</i>	DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>7/18/85</i>
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Rodney L. Brimball, MD</i>		22d. ADDRESS <i>1839 Forest Dr. Annapolis, MD 21401</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>	23b. DATE <i>July 22, 1985</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland PG MD</i>
24. FUNERAL DIRECTOR NAME <i>Taylor Funeral Chapel - Annapolis, MD</i>		25a. DATE REC'D. BY REGISTRAR <i>JUL 22 1985</i>	25b. REGISTRAR'S SIGNATURE <i>Car Davidson-Randall</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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213052

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 REG. NO. 18544		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR AM			
1. DECEASED NAME (TYPE OR PRINT) Karsten		MIDDLE Chester		LAST HANSEN		July 28, 1985		10:20 AM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR November 7, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 88		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Norway		7b. CITIZEN OF WHAT COUNTRY? Norway		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.			
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Home Builder	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Pr George's		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12417 Sandal Lane 20715	
14. FATHER'S NAME FIRST Carl MIDDLE Hansen LAST				15. MOTHER'S MAIDEN NAME FIRST Andirina MIDDLE Gulicksen LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. --- -- 095-14-5634		17. INFORMANT ADDRESS 12417 Sandal Lane Sven O. Hansen Bowie, Maryland 20715					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD, CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pancytopenia & Malnutrition</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hepes Zoster - O.B.S.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7-22-85, to 7-28-85, that (I) (we) lost saw the deceased alive on 7-28-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Mustafa C Oz MD</u> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7-28-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mustafa C Oz MD				22e. ADDRESS 605 B & A Blvd SP. MD, 2116					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 30, 1985		23c. NAME OF CEMETERY OR CREMATORY Lakemont Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville Anne Arundel, MD			
24. FUNERAL DIRECTOR NAME Beall Funeral Home		16000 Annapolis Road Bowie, MD 20715-3048		25a. DATE REC'D. BY REGISTRAR JUL 30 1985		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1140	1141	1142	1143	1144	1145	1146	1147	1148	1149	1150	1151	1152	1153	1154	1155	1156	1157	1158	1159	1160	1161	1162	1163	1164	1165	1166	1167	1168	1169	1170	1171	1172	1173	1174	1175	1176	1177	1178	1179	1180	1181	1182	1183	1184	1185	1186	1187	1188	1189	1190	1191	1192	1193	1194	1195	1196	1197	1198	1199	1200	1201	1202	1203	1204	1205	1206	1207	1208	1209	1210	1211	1212	1213	1214	1215	1216	1217	1218	1219	1220	1221	12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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 RES. NO. 1854DT5	
1. DECEASED NAME (TYPE OR PRINT) MOLLY FIRST MIDDLE LAST HARRISON			2a. DATE OF DEATH MONTH JULY DAY 28 , YEAR 1985		2b. HOUR 1109 AM
3. SEX Female	4. RACE Color negro	5. DATE OF BIRTH MONTH 4 DAY 6 YEAR 1911		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sumter, S.C.		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		10. CITY OR TOWN OF DEATH GLEN BURNIE			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF DECEASED IN A HOSPITAL, GIVE ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY Resturant	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY A.A. Co. 13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS & ZIP CODE 9 Scott Ave 21061	
14. FATHER'S NAME FIRST John MIDDLE LAST Leighton		15. MOTHER'S MAIDEN NAME FIRST Hollie MIDDLE LAST Gas		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
16b. SOCIAL SECURITY NO. 213-10-9157		17. INFORMANT Mrs. Margaret Hockaday		ADDRESS 3702 Holly Lane Rd 21220	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriole Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriole Heart Disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Arteriole Heart Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 7/28/85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22. I certify that (1) (this hospital) attended the deceased from 7/28/85 19 to 7/28/85 19, that (1) (we) last saw the deceased alive on 7/28/85 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death, so state.)					
22a. SIGNATURE Jorge B. Ramirez M.D.		DEGREE M.D.		22b. DATE SIGNED 7/29/85	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) JORGE B. RAMIREZ, M. D.		22d. ADDRESS 7845 OAKWOOD ROAD, SUITE 205 GLEN BURNIE, MARYLAND 21061		22e. MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 2, 1985		23c. NAME OF CEMETERY OR CREMATORY Baltimore National	
23d. LOCATION Balto.		CITY OR TOWN		COUNTY md STATE	
24. FUNERAL DIRECTOR NAME James A. Morton & Sons		ADDRESS 1701 Laney St 21217		25a. DATE REC'D. BY REGISTRAR JUL 30 1985	
25b. REGISTRAR'S SIGNATURE W. Harrison Handall					

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OFFICE OF THE
SOLICITOR GENERAL

UNITED STATES
DEPARTMENT OF JUSTICE

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
PAULINE JANE HART		JULY 06, 1985		628 PM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR MONTHS DAYS	
FEMALE	WHITE	MARCH 9, 1913	72 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	U.S.A.		ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		HOMEMAKER		OWN HOME
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
MD	A.A.	GLEN BURNIE	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	APT. 867 102 BALT. & ANNAPOLIS BLVD. 21061	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
JOHN HISSEY		PAULINE WOLFF			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (NIECE) ADDRESS	
NO		217.07.4660		7728 WALTERS ROAD MRS. PATRICIA C. DELEONARDO PASADENA, MD. 21122	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.					
IMMEDIATE CAUSE (a) <u>acute myocardial infarction with</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiogenic Shock.</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/6</u> 19 <u>85</u> to <u>7/6</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>7/6</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Dalitt S. Sawhney</u>				7/7/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
DALITT S. SAWHNEY		7422 BALTIMORE-ANNAPOLIS BLVD. GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		JULY 9, 1985		MEADOWRIDGE MEM. PARK	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
SINGLETON FUNERAL HOME GLEN BURNIE, MD 21061		JUL 09 1985		<u>[Signature]</u>	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO. 18547

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Violet Ann Hawn		2a. DATE OF DEATH MONTH DAY YEAR July 29, 1985		2b. HOUR P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 3, 1894	
6. AGE (IN YEARS LAST BIRTHDAY) 90		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.			
10. CITY OR TOWN OF DEATH Millersville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Knollwood Manor		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
12b. KIND OF BUSINESS OR INDUSTRY Home		13a. STATE MD			
13b. COUNTY A.A.		13c. CITY OR TOWN Lothian		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 81 Edward Lane-20711		14. FATHER'S NAME FIRST MIDDLE LAST Charles Wood			
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Kay		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 577-545787		17. INFORMANT ADDRESS Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic renal Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Atherosclerotic Heart Disease					
19a. DATE OF OPERATION 7-1		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 12-1		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7-1 1985, to 7-29 1985, that (I) (we) last saw the deceased alive on 7-1 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Long S. Hsu		DEGREE M.D.		22c. DATE SIGNED 7-29-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Long S. Hsu		22e. ADDRESS 7845 Oakwood Rd #205 Glen Burnie MD 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 30, 1985		23c. NAME OF CEMETERY OR CREMATORY St. Lincoln	
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood PG MD		24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel-Annapolis MD			
25a. DATE REC'D. BY REGISTRAR JUL 31 1985		25b. REGISTRAR'S SIGNATURE John Davidson			

BP

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>Nathan Scott Nead</u>			2b. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH <u>7</u> DAY <u>24</u> YEAR <u>1985</u>			2d. HOUR <u>1800</u>		
3. SEX <u>MALE</u>	4. RACE <u>WHITE</u>	5. DATE OF BIRTH MONTH <u>APRIL</u> DAY <u>24</u> YEAR <u>1969</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>16</u> YRS.	IF UNDER 1 YR. MONTHS <u> </u> DAYS <u> </u>	IF UNDER 24 HRS. HOURS <u> </u> MIN. <u> </u>	2c. DATE PRONOUNCED DEAD <u>7 30 1985</u>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>ANNE ARUNDEL</u> MD.		
10. CITY OR TOWN OF DEATH <u>ARNOLD</u>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>984 DEEP CREEK AVE</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>STOCK CLERK</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>FOOD STORE</u>
13a. STATE <u>MARYLAND</u>			13b. COUNTY <u>ANNE ARUNDEL</u>	13c. CITY OR TOWN <u>ARNOLD</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <u>984 DEEP CREEK AVE. 21012</u>		
14. FATHER'S NAME FIRST <u>EDWARD</u> MIDDLE <u>L.</u> LAST <u>NEAD, SR.</u>			15. MOTHER'S MAIDEN NAME FIRST <u>NADINE</u> MIDDLE <u> </u> LAST <u>RAMEY</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>NO</u>			16b. SOCIAL SECURITY NO. <u> </u>			17. INFORMANT ADDRESS <u>EDWARD NEAD, SR. (SAME AS 13)</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral trauma - gun shot to head</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u> </u> DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>James E. Wheeler, M.D.</u>			TITLE (SPECIFY) <u>M.D. Dep</u>			MEDICAL EXAMINER DATE SIGNED <u>7-30-85</u>		
EXAMINER'S NAME (TYPE OR PRINT) <u>James E. Wheeler, M.D.</u>			ADDRESS <u>1116 Gumbottom Road</u>			CITY OR TOWN <u>Crownsville</u> STATE <u>21032</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>AUGUST 2, 85</u>			23c. NAME OF CEMETERY OR CREMATORY <u>GUEN HAVEN CEMETERY</u>		
23d. LOCATION CITY OR TOWN <u>GUEN BURNIE</u>			COUNTY <u>ANNE ARUNDEL</u>			STATE <u>MD</u>		
24. FUNERAL DIRECTOR NAME <u>BARRANCO FUNERAL HOME</u>			ADDRESS <u>501 RITCHIE HWY. SEVERNA PARK, MD.</u>			25a. DATE REC'D. BY REGISTRAR <u>AUG 02 1985</u>		
25b. REGISTRAR'S SIGNATURE <u>Johanna Davidson-Randall</u>								

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DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the four pages (Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal committee must be notified.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH85 18549
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elsie A. Hiatt			2a. DATE OF DEATH MONTH DAY YEAR 7-14-1985		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 2, 1902	6. AGE (IN YEARS (LAST BIRTHDAY)) 83 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.		
10. CITY OR TOWN OF DEATH Shady Side	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1712 Bayview Rd. Idlewilde		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Household	
13a. STATE Md.			13b. COUNTY AACo.	13c. CITY OR TOWN Shady Side	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Adam Meininger			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Hutt		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-01-6931A	17. INFORMANT ADDRESS A Norman Beckwith Fairfax Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>stroke</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>June 82</u> , to <u>7/14</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>June 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>William A. Dabbs</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/15/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DABBS, W.A.</u>		22e. ADDRESS <u>203 GIDDINGS AVE</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-17-85	23c. NAME OF CEMETERY OR CREMATORY City Fairfax Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Fairfax Va.		
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home		ADDRESS Annapolis, Md.		25a. DATE REC'D. BY REGISTRAR <u>11/11 18 1985</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 NO. 18550

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
HERBERT STANLEY HILLIARD				7-28-85		10 ⁵⁰ PM			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE	B	MAY 25 1911		74		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
ARKANSAS	U.S.A.			A.A.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
ANNAPOLIS	ANNE ARUNDEL GENERAL			EDUCATION		SCHOOL			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
MD	ALTA	ANNAPOLIS		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3546 NARRAGANSETT 21403			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
JAMES		MINNIE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT					
NO		432-12-3695		ALMA LACIEL HILLIARD 3546 Narrag					
18. CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Renal Failure									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) Diabetes mellitus									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
prostate cancer, Hypertension, Arteriosclerosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
JACK R. LICHTENSTEIN MD		20 Ridgely Ave ANNAPOLIS, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		Aug 2, 1985		Hillcrest Mem Gard		ANNAPOLIS A.A. MD			
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			
C.B. Hicks		1922 Forest Drive		ANNAPOLIS		AUG 6 1985 John Davidson-Randall			

4.2.4

192028

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 4 should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 5 1 8 5 5 1
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ernest John Hoffa, Sr.			2a. DATE OF DEATH MONTH DAY YEAR JULY 7, 1985			2b. HOUR 0845 AM					
3. SEX Male		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Nov. 14, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Johnston, PA		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD					
12. CITY OR TOWN OF DEATH Ft. Meade		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kimbrough Army Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Air Force		15. KIND OF BUSINESS OR INDUSTRY Armed Forces			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland			16b. COUNTY Anne Arundel		16c. CITY OR TOWN Hanover		16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16e. STREET ADDRESS 7203 Forrest Avenue 21076		
17. FATHER'S NAME FIRST MIDDLE LAST John Hoffa			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAY AULANBACH			19. 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				19. 16b. SOCIAL SECURITY NO. 216.34.6098	
19. 16c. IF YES, GIVE WAR OR DATES WWII, KOREAN			20. INFORMANT (SON) MR. RAYMOND J. HOFFA			20. ADDRESS RT. 2 BOX 61 SHELDON, MO. 64784			20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes		
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Respiratory Failure										21. 2 Days 3 Days	
22. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.											
23. DATE OF OPERATION			23. CONDITION FOR WHICH OPERATION WAS PERFORMED			24. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		24. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
25. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			25. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			25. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
26. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			26. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			26. LOCATION STREET CITY OR TOWN COUNTY STATE					
27. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
27. SIGNATURE <i>Joseph D. Zeligs</i> M.D.			27. DEGREE M.D.			27. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			27. DATE SIGNED 7 July 85		
27. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph D. Zeligs, LTC, MC, Chief			27. ADDRESS KIMBROUGH ARMY COMMUNITY HOSPITAL								
28. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			28. DATE JULY 11, 1985		28. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PARK		28. LOCATION CITY OR TOWN COUNTY STATE ELKRIDGE HOWARD MD.				
29. FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME GLEN BURNIE, MD 21061			29. DATE REC'D. BY REGISTRAR JUL 09 1985			29. REGISTRAR'S SIGNATURE <i>Richard A. Riddle</i>					

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

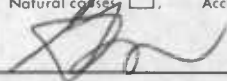
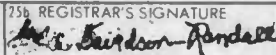
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25M

BP

DHMH - 17
(VR A15 ME (5))1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 8 5 5 2

1. DECEASED NAME (TYPE OR PRINT) Russell Lee Howard				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 7 DAY 8 YEAR 1985				2b. HOUR 12:50	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Sept. DAY 19 YEAR 1947	6. AGE (IN YEARS) (LAST BIRTHDAY) 37 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN 0	IF UNDER 24 HRS. HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD MONTH 7 DAY 9 YEAR 1985			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.			
10. CITY OR TOWN OF DEATH Ferndale		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1420 Olen Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY Pallet Co.	
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Ferndale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1420 Olen Drive 21061	
14. FATHER'S NAME FIRST Milford MIDDLE Howard LAST Howard				15. MOTHER'S MAIDEN NAME FIRST Doris MIDDLE M. LAST Maraskey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) Vietnam		16b. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS 1004 Craftswood Road Doris Ackerman Baltimore, Md, 21228			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound to chest (handgun) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) — DUE TO, OR AS A CONSEQUENCE OF (c) —									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 7 8 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self inflicted				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET 1420 Olan Drive, CITY OR TOWN Ferndale, COUNTY A.A. Co., STATE MD				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER					DATE SIGNED 7/9/85	
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.			ADDRESS 111 Penn St. Balto.MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 7/10/85		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN Catonsville COUNTY Baltimore STATE Md.		
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228						25a. DATE REC'D. BY REGISTRAR JUL 11 1985		25b. REGISTRAR'S SIGNATURE 	

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5201049

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXCLUDED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE REASON FOR DELAY IN PENCIL IN ITEM 19. RETAIN PAGE 5 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THIS FORM. PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR		REG. NO. 85533	
1. DECEASED NAME (TYPE OR PRINT) HERMAN Glenn HUFFMAN, Jr.		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 7 DAY 14 YEAR 1985	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH May DAY 8 YEAR 1937	6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Annapolis,	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Landscaper	12b. KIND OF BUSINESS OR INDUSTRY Landscaping
13a. STATE Maryland		13b. COUNTY Anne Arundel	13c. CITY OR TOWN Pasadena
14. FATHER'S NAME FIRST Herman MIDDLE G. LAST Huffman, Sr.		15. MOTHER'S MAIDEN NAME FIRST Barbara MIDDLE Katherine LAST Bowman	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 245-52-7306	
17. INFORMANT Margaret Huffman, Pasadena, Md.		ADDRESS 887 Woods Rd. 21122	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE James E. Wheeler M.D.		TITLE (SPECIFY) Dis MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) James E. Wheeler, M.D.		ADDRESS 1176 Gumbottom Road Coonville 21032	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 18, 85	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, Anne Arundel, Md.	
24. FUNERAL DIRECTOR NAME McCully Funeral Home		25a. DATE REC'D. BY REGISTRAR JUL 17 1985	
25b. REGISTRAR'S SIGNATURE [Signature]			

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RECEIVED
JAN 10 1964

ST. LOUIS, MO. JAN 10 1964

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a memorandum or letter body.]

2000000
JAN 10 1964
ST. LOUIS, MO.

[The following text is extremely faint and largely illegible, appearing to be a memorandum or letter body.]

5191093

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDRIE LOUISE HUGHES						2a. DATE OF DEATH MONTH DAY YEAR July 2, 1985		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 14, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co., MD.			
10. CITY OR TOWN OF DEATH Glen Burnie,		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House-wife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Glen Burnie						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 626 Opel Rd. / 21061	
14. FATHER'S NAME FIRST MIDDLE LAST William - DeWeese						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bartley - Skeens			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO - -				16b. SOCIAL SECURITY NO. 236-36-2470		17. INFORMANT ADDRESS Ray Hughes / 626 Opel rd. / 21061			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-pulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic bronchial asthma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Partial intestinal obstruction due to hernia</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Intestinal hernia</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 min.</i> <i>Several years.</i> <i>Hernia</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>7/1</i> 19 <i>85</i> , to <i>7/2</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>7/1</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>R.M. McLaughlin M.D.</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED July 2, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Randall McLaughlin				22e. ADDRESS 3708 Mountain Rd. / Pasadena, Md. 21122					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 5, 85		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, Anne Arundel, Md.			
24. FUNERAL DIRECTOR NAME McCully Funeral Home / Pasadena, Md. 21122				25a. DATE REC'D. BY REGISTRAR JUL 03 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

01211

NAME		ADDRESS		CITY		STATE		ZIP	
J. V. Williams		1234 Main St.		Springfield		Illinois		62761	
C. L. Smith		5678 Oak Ave.		Chicago		Illinois		60642	
M. J. Brown		9012 Elm St.		Peoria		Illinois		61603	
R. S. Jones		3456 Pine St.		Rockford		Illinois		61101	
T. A. White		7890 Maple St.		Joliet		Illinois		60431	
K. B. Black		2345 Cedar St.		Naperville		Illinois		60563	
L. M. Green		6789 Birch St.		Aurora		Illinois		60009	
N. P. Hall		10123 Walnut St.		Evanston		Illinois		60201	
D. Q. King		4567 Spruce St.		Oak Park		Illinois		60454	
F. R. Lee		8901 Ash St.		Schaumburg		Illinois		60196	
G. T. Scott		21098 Hickory St.		Morton		Illinois		60451	
H. U. Adams		54321 Willow St.		Normal		Illinois		62550	
I. V. Baker		98765 Poplar St.		Danville		Illinois		60119	
J. W. Carter		13579 Sycamore St.		Mantoloking		Illinois		60148	
K. X. Davis		24680 Chestnut St.		Streator		Illinois		61364	
L. Y. Evans		35791 Elm St.		Galesburg		Illinois		61234	
M. Z. Foster		46802 Maple St.		Macomb		Illinois		61456	
N. A. Gibson		57913 Oak St.		Pontiac		Illinois		61761	
O. B. Harris		68024 Pine St.		Freeport		Illinois		61032	
P. C. Ingram		79135 Cedar St.		Mendota		Illinois		61840	
Q. D. Jackson		80246 Birch St.		Bloomington		Illinois		61701	
R. E. Keller		91357 Walnut St.		Urbana		Illinois		61556	
S. F. Lewis		12468 Spruce St.		Champaign		Illinois		61820	
T. G. Martin		23579 Ash St.		Vandalia		Illinois		61873	
U. H. Nelson		34680 Hickory St.		Carbondale		Illinois		62901	
V. I. Owen		45791 Willow St.		Pittsburg		Illinois		62451	
W. J. Parker		56802 Poplar St.		Hannibal		Illinois		62150	
X. K. Quinn		67913 Sycamore St.		Keokuk		Illinois		62701	
Y. L. Reed		78024 Chestnut St.		Tipton		Illinois		62680	
Z. M. Stewart		89135 Elm St.		Harrisburg		Illinois		62929	
A. N. Taylor		90246 Maple St.		Shelburne		Illinois		62969	
B. O. Vance		10357 Oak St.		Holt		Illinois		62950	
C. P. Webb		21468 Pine St.		Harrisburg		Illinois		62929	
D. Q. White		32579 Cedar St.		Harrisburg		Illinois		62929	
E. R. Black		43680 Birch St.		Harrisburg		Illinois		62929	
F. S. Green		54791 Walnut St.		Harrisburg		Illinois		62929	
G. T. Hall		65802 Spruce St.		Harrisburg		Illinois		62929	
H. U. King		76913 Ash St.		Harrisburg		Illinois		62929	
I. V. Lee		87024 Hickory St.		Harrisburg		Illinois		62929	
J. W. Scott		98135 Willow St.		Harrisburg		Illinois		62929	
K. X. Adams		10246 Poplar St.		Harrisburg		Illinois		62929	
L. Y. Baker		21357 Sycamore St.		Harrisburg		Illinois		62929	
M. Z. Carter		32468 Chestnut St.		Harrisburg		Illinois		62929	
N. A. Davis		43579 Elm St.		Harrisburg		Illinois		62929	
O. B. Evans		54680 Maple St.		Harrisburg		Illinois		62929	
P. C. Foster		65791 Oak St.		Harrisburg		Illinois		62929	
Q. D. Gibson		76802 Pine St.		Harrisburg		Illinois		62929	
R. E. Harris		87913 Cedar St.		Harrisburg		Illinois		62929	
S. F. Ingram		98024 Birch St.		Harrisburg		Illinois		62929	
T. G. Jackson		10135 Walnut St.		Harrisburg		Illinois		62929	
U. H. Keller		21246 Spruce St.		Harrisburg		Illinois		62929	
V. I. Lewis		32357 Ash St.		Harrisburg		Illinois		62929	
W. J. Martin		43468 Hickory St.		Harrisburg		Illinois		62929	
X. K. Nelson		54579 Willow St.		Harrisburg		Illinois		62929	
Y. L. Owen		65680 Poplar St.		Harrisburg		Illinois		62929	
Z. M. Parker		76791 Sycamore St.		Harrisburg		Illinois		62929	
A. N. Quinn		87802 Chestnut St.		Harrisburg		Illinois		62929	
B. O. Reed		98913 Elm St.		Harrisburg		Illinois		62929	
C. P. Stewart		10024 Maple St.		Harrisburg		Illinois		62929	
D. Q. Taylor		21135 Oak St.		Harrisburg		Illinois		62929	
E. R. Vance		32246 Pine St.		Harrisburg		Illinois		62929	
F. S. Webb		43357 Cedar St.		Harrisburg		Illinois		62929	
G. T. White		54468 Birch St.		Harrisburg		Illinois		62929	
H. U. Black		65579 Walnut St.		Harrisburg		Illinois		62929	
I. V. Green		76680 Spruce St.		Harrisburg		Illinois		62929	
J. W. Hall		87791 Ash St.		Harrisburg		Illinois		62929	
K. X. King		98802 Hickory St.		Harrisburg		Illinois		62929	
L. Y. Lee		10024 Willow St.		Harrisburg		Illinois		62929	
M. Z. Scott		21135 Poplar St.		Harrisburg		Illinois		62929	
N. A. Adams		32246 Sycamore St.		Harrisburg		Illinois		62929	
O. B. Baker		43357 Chestnut St.		Harrisburg		Illinois		62929	
P. C. Carter		54468 Elm St.		Harrisburg		Illinois		62929	
Q. D. Davis		65579 Maple St.		Harrisburg		Illinois		62929	
R. E. Evans		76680 Oak St.		Harrisburg		Illinois		62929	
S. F. Foster		87791 Pine St.		Harrisburg		Illinois		62929	
T. G. Gibson		98802 Cedar St.		Harrisburg		Illinois		62929	
U. H. Harris		10024 Birch St.		Harrisburg		Illinois		62929	
V. I. Ingram		21135 Walnut St.		Harrisburg		Illinois		62929	
W. J. Jackson		32246 Spruce St.		Harrisburg		Illinois		62929	
X. K. Keller		43357 Ash St.		Harrisburg		Illinois		62929	
Y. L. Lewis		54468 Hickory St.		Harrisburg		Illinois		62929	
Z. M. Martin		65579 Willow St.		Harrisburg		Illinois		62929	
A. N. Nelson		76680 Poplar St.		Harrisburg		Illinois		62929	
B. O. Owen		87791 Sycamore St.		Harrisburg		Illinois		62929	
C. P. Parker		98802 Chestnut St.		Harrisburg		Illinois		62929	
D. Q. Reed		10024 Elm St.		Harrisburg		Illinois		62929	
E. R. Stewart		21135 Maple St.		Harrisburg		Illinois		62929	

214004

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and autopsy performed.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 NO. 18555

1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CLARENCE W HUTCHINS			2a. DATE OF DEATH MONTH DAY YEAR 7-23-85		2b. HOUR MIN. 12⁰⁴ P.M.
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 10 19 01	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Banker	12b. KIND OF BUSINESS OR INDUSTRY Banking	
13a. STATE Md.		13b. COUNTY A.A.	13c. CITY OR TOWN Friendship	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 20758
14. FATHER'S NAME FIRST MIDDLE LAST F. Clarence Hutchins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane Webb			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-18-1655		17. INFORMANT ADDRESS 3712 Manor Rd. Chevy Chase, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct + renal failure					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 19 85 to death 19 85 , that (I) (we) lost saw the deceased alive on 7/23 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE Jacob Teitelbaum		DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jacob Teitelbaum		22e. ADDRESS 20736 Owings, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/27/85	23c. NAME OF CEMETERY OR CREMATORY Friendship Church		23d. LOCATION CITY OR TOWN COUNTY STATE Friendship AA Md.
24. FUNERAL DIRECTOR NAME Rausch Funeral Home		ADDRESS 20736 Owings, Md.		25a. DATE REC'D. BY REGISTRAR JUL 31 1985	25b. REGISTRAR'S SIGNATURE [Signature]

BP _____

203441

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 REG. NO.

185 EDT6

1. DECEASED NAME (TYPE OR PRINT) CHESTER . NMN JACKSON			2a. DATE OF DEATH MONTH JULY DAY 13 YEAR 1985			2b. HOUR 945 PM			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH Oct DAY 02 YEAR 1913		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Elensburg, Wash		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN BALTIMORE CITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Technician		12b. KIND OF BUSINESS OR INDUSTRY Kennecott	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Glen Burnie			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 120 Bonnie View Road 21061	
14. FATHER'S NAME FIRST John MIDDLE W. LAST Jackson			15. MOTHER'S MAIDEN NAME FIRST Vivian MIDDLE L. LAST (unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (Wife) Mrs. Rose Jackson ADDRESS same as 13e		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) old age, Multiple deca... DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from 7/13/85, 1985, to 7/15/85, 1985, that (I) (we) last saw the deceased alive on 7/13/85, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE H. Towhidian		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED July 15, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAMID TOWHIDIAN, M. D.		22e. ADDRESS 3236 MOUNTAIN ROAD PASADENA, MARYLAND 21122					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 17, 1985		23c. NAME OF CEMETERY OR CREMATORY Memorial Meadowridge Park		23d. LOCATION CITY OR TOWN Elkridge COUNTY Howard STATE Maryland	
24. FUNERAL DIRECTOR Singleton Funeral Home, Glen Burnie, Md.				25a. DATE REC'D. BY REGISTRAR JUL 16 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and send them with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

207083

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1. FOR
STATE
REGISTRAR

8 REG. NO. 18557

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HERBERT W. JANKOWSKI SR.		2a. DATE OF DEATH MONTH DAY YEAR July 19 1985		2b. HOUR M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOV. 3 1911	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 73 YRS.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 208 SUMMIT AVE.		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL CO. MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN GLEN BURNIE	
14. FATHER'S NAME FIRST MIDDLE LAST STANISLAUS JANKOWSKI		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) YES		16b. SOCIAL SECURITY NO. 100-11		17. INFORMANT ADDRESS HERBERT JANKOWSKI JR. SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRO VASCULAR ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): SEVERE EMPHYSEMA / CONGESTIVE CARDIAC FAILURE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7/15 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE	
22a. I certify that (this hospital) attended the deceased from 7/15 1985 to 7/18 1985 , that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE M.D.		22c. DATE SIGNED 7/22/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) O.D. ZIMMERMANN		22e. ADDRESS 200 HOSPITAL DR. GLEN BURNIE			
23a. BURIAL, CREMATION, REMOVAL (OR IF V) BURIAL		23b. DATE July 22 1985		23c. NAME OF CEMETERY OR CREMATORY DULANEY VALLEY	
23d. FUNERAL DIRECTOR NAME RAYMOND L. KACZOROWSKI		23e. ADDRESS 2325 FLEET ST.		23f. LOCATION CITY OR TOWN COUNTY BALTIMORE CO. MD.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR JUL 22 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 5 1 8 5 5 8
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) BARRY GUNN JONES			2a DATE OF DEATH MONTH DAY YEAR 3 12 85			2b HOUR 3 45 AM			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 3 12 85		6 AGE (IN YEARS LAST BIRTHDAY) 2 HRS		7 IF UNDER 1 YEAR MONTHS DAYS 2 05	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.			
10 CITY OR TOWN OF DEATH ANNAPOLIS		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NA		12b KIND OF BUSINESS OR INDUSTRY NA	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE md.		13b COUNTY A.A. Co		13c CITY OR TOWN Edgewater		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 1640 Old Town Rd. Edgewater, Md. 21037	
14 FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PATRICIA M. NA					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17 INFORMANT ADDRESS 1640 Old Town Rd Edgewater MD 21037					
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IMMATURE FETUS. CARDIO RESP DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) FAILURE DUE TO ABOVE DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HRS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NONE									
19a DATE OF OPERATION NONE		19b CONDITION FOR WHICH OPERATION WAS PERFORMED NONE				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 ____		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) ---					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE Baltimore					
22a I certify that (I) (this hospital) attended the deceased from 3/12/85 19 85 to 3/12/85 19 85 , that (I) (we) last saw the deceased alive on 3/12/85 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE AZAM				DEGREE MD				22c DATE SIGNED 3/12/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) AZAM				22e ADDRESS BALG MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE 8-2-85		23c NAME OF CEMETERY OR CREMATORY WESTERN PARK		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore			
24 FUNERAL DIRECTOR NAME T. A. Hardesty				ADDRESS ANNAPOLIS MD-21401		25a DATE REC'D BY REGISTRAR AUG 6 1985			
				25b REGISTRAR'S SIGNATURE J. W. Harrison					

64005

211018

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 NO.

1855EDV

1. DECEASED NAME (TYPE OR PRINT) RUTH ANNA JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR JULY 23, 1985		2b. HOUR 832 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3 11 18		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			10. CITY OR TOWN OF DEATH GLEN BURNIE		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Mercantile Ind.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY A.A.	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John E. Crout			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna W. Warner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-09-9150		17. INFORMANT ADDRESS Lester F. Johnson Same as 13c	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe aortic stenosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 23</u> 19 <u>85</u> to <u>July 23</u> 19 <u>85</u> that (we) lost saw the deceased give on <u>July 23</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Charles J. Wu</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>July 23, 1985</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES J. WU, M.D.		22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 204 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/26/85		23c. NAME OF CEMETERY OR CREMATORY Good Shepherd Cem.	
23d. LOCATION (CITY OR TOWN) STATE Ellicott City Howard Md		23e. DATE REC'D BY REGISTRAR JUL 26 1985		23f. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR NAME ADDRESS George J. Gonca 4001 Ritchie Hgwy Balto Md					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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205014

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 REC. NO. 185 670

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHEA MN JONES			2a. DATE OF DEATH MONTH DAY YEAR JULY 16, 1985		2b. HOUR 150 PM
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 5 3 1918		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNKNOWN		12b. KIND OF BUSINESS OR INDUSTRY -----
13a. STATE MARYLAND		13b. COUNTY NORTH ARUNDEL	13c. CITY OR TOWN GLEN BURNIE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT JONES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ANDERSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS ELIZABETH JONES 123 S. JENNINGS RD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopalm. Arrest</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>40 min</u>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic + Hypertensive Enceph</u>					<u>2 wks</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>DM, ABP, Renal Failure</u>					<u>1 month</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>UTE</u>					
19a. DATE OF OPERATION <u>7/13/85</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Peritoneal Dialysis</u>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OR INJURY IN PART 18; PART 2 OR PART 3) <u>Cardiopalm. Arrest</u>	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT SCHOOL <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>7/14</u> to <u>7/16</u> 19 <u>85</u> and that (2) my opinion death occurred on the date and hour and from the causes stated above (1) (we did not) view the body after death.					
22b. SIGNATURE <u>David A. Schwartz</u>					22c. DATE SIGNED <u>7/16/85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID A. SCHWARTZ, D.O.					22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 200 GLEN BURNIE, MARYLAND 21061
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/20/85	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MD.
24. FUNERAL DIRECTOR NAME E.L. PHILLIPS FUNERAL HOME 1721 N. MONROE ST.			25a. DATE RECEIVED BY REGISTRAR JUL 19 1985		
25b. REGISTRAR'S SIGNATURE					

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.



199027

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REC'D NO. 18561

1. DECEASED NAME (TYPE OR PRINT) LEROY THOMAS KELLEY			2a. DATE OF DEATH MONTH DAY YEAR 7-3-85		2b. HOUR M
3. SEX MALE	4. RACE CAUCASION	5. DATE OF BIRTH MONTH DAY YEAR 5-4-07	6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD		
10. CITY OR TOWN OF DEATH SEVERNA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 202 GIDDINGS ROAD	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER	12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND	13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN SEVERNA PARK	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 202 GIDDINGS ROAD 21146	
14. FATHER'S NAME FIRST MIDDLE LAST MARTIN	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARA JOHNSON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 212-95-4345	17. INFORMANT ADDRESS HILDA KELLEY (Same as #13)			
18. CAUSE OF DEATH Enter only one cause per line. (a) Metastatic Lung Cancer PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> OUTSIDE <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 6-27-85 to 7-3-85 , that (1) (he) last saw the deceased alive on 6-27-85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (and) not see the body after death.					
27b. SIGNATURE Arno G. Alexander MD		DEGREE MD		27c. DATE SIGNED 7-5-85	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) Arno G. Alexander MD		27e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) ENTOMBMENT	23b. DATE 7-6-85	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE ANNE ARUNDEL MD		
24. FUNERAL DIRECTOR NAME ROBERT BARRANCO		495 RITCHIE AVE ADDRESS SEVERNA PARK MD		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 11/10/85	

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in my the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100% COTTON FIBER



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152034

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 1856 EBT

1. DECEASED NAME (TYPE OR PRINT) ROBERT E KOHLHAER			2a. DATE OF DEATH MONTH JULY DAY 12 YEAR 1985			2b. HOUR 525 PM									
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 2 DAY 5 YEAR 06		6. AGE (IN YEARS LAST BIRTHDAY) 79		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD						
10. CITY OR TOWN OF DEATH GLEN BURNIE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sheet Metal			12b. KIND OF BUSINESS OR INDUSTRY						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE Maryland			13b. COUNTY A. A.			13c. CITY OR TOWN Pasadena			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 346 Sturtons Lane 21122			
14. FATHER'S NAME FIRST UNKNOWN MIDDLE UNKNOWN LAST UNKNOWN						15. MOTHER'S MAIDEN NAME FIRST UNKNOWN MIDDLE UNKNOWN LAST UNKNOWN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO, GIVE DATE) NO				16b. SOCIAL SECURITY NO. 217-05-6425				17. INFORMANT Betty Weihrer				ADDRESS 344 Sturtons Lane 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMA OF PROSTATE DUE TO, OR AS A CONSEQUENCE OF (c) 4 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 7/12 , 19 85 , to 7/12 , 19 85 , that (I) (we) last saw the deceased alive on 7/12/85 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Duncan Salmon MD								DEGREE		22c. DATE SIGNED 7/13/85		22d. PHYSICIAN'S NAME (TYPE OR PRINT) DUNCAN SALMON, M.D.			
22e. ADDRESS 325 HOSPITAL DRIVE, SUITE 208 GLEN BURNIE, MARYLAND 21061								22f. ADDRESS		22g. ADDRESS		22h. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7-16-85				23c. NAME OF CEMETERY OR CREMATORY Cedar Hill				23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. Md.			
24. FUNERAL DIRECTOR McCully Funeral Home								24a. DATE REC'D. BY REGISTRAR 297 Patapsco Ave Balto. Md. 21225		24b. REGISTRAR'S SIGNATURE JUL 15 1985		24c. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

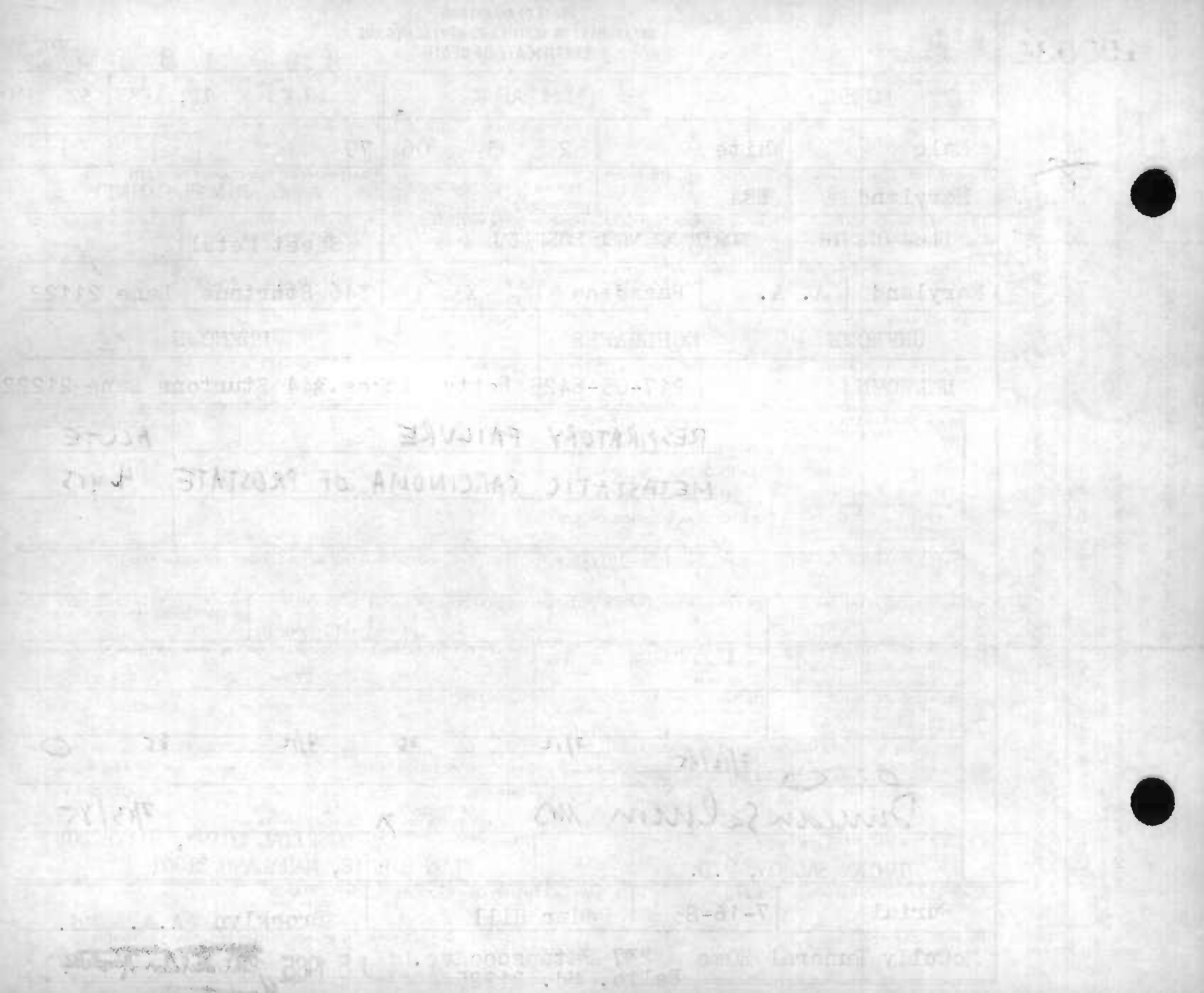
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



150124

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

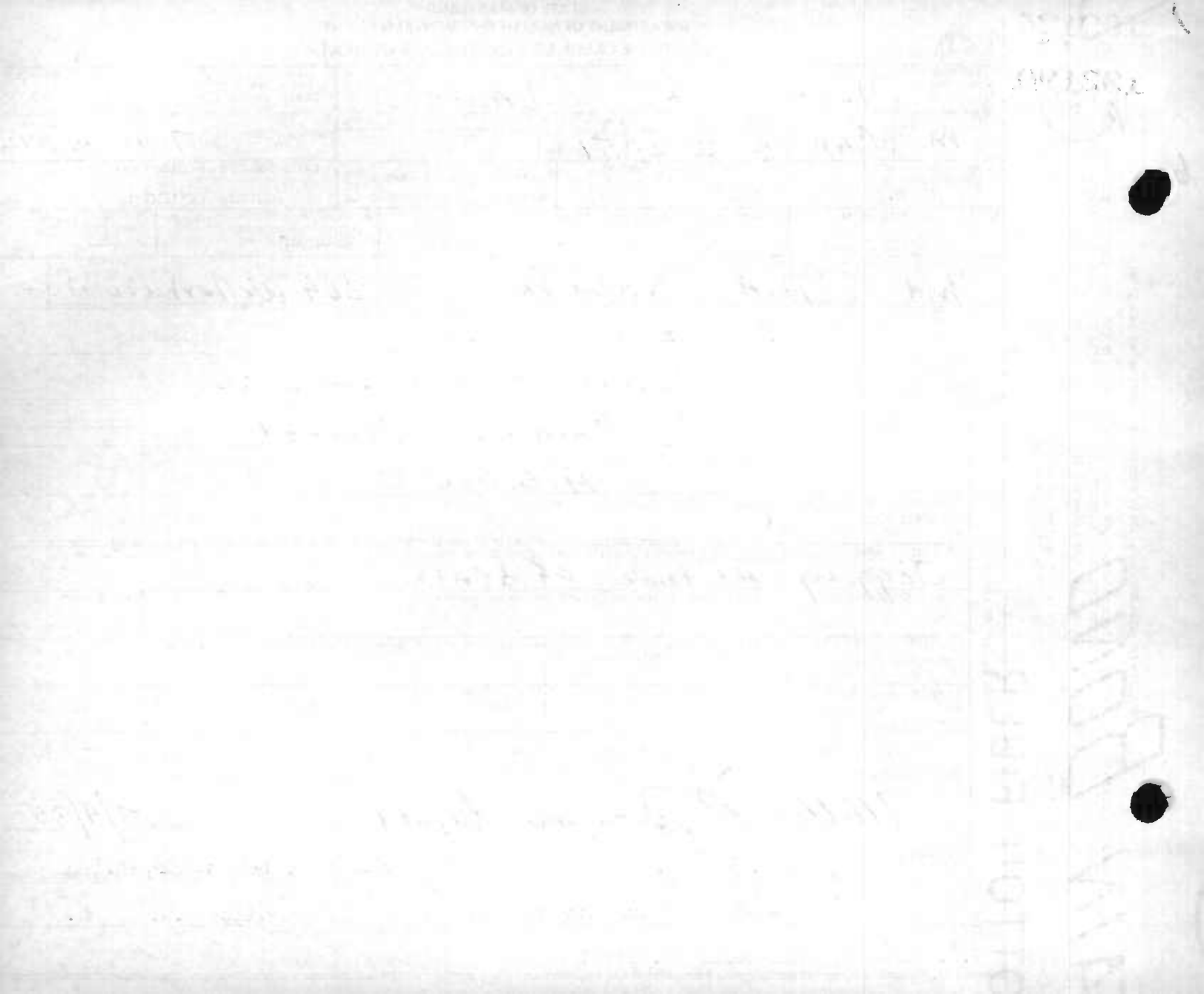
REG. NO. 8 5 6 3

1. DECEASED NAME (TYPE OR PRINT) Chester K. Laufer			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 7 4 85			2b. HOUR 19 1012		
3. SEX M	4. RACE CAU	5. DATE OF BIRTH MONTH DAY YEAR 6 20 34	6. AGE (IN YEARS) (LAST BIRTHDAY) 51	IF UNDER 1 YR. MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 4 85		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel		
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Sales
13a. STATE md.			13b. COUNTY A.A.	13c. CITY OR TOWN Severna Pk.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 369 Wellerburn Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST Chester A. Laufer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esta McCarthy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean		17. INFORMANT Virginia M. Laufer #13e		ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: A.S.C.V.D. (b) A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Jogging At time of death.								
19a. DATE OF OPERATION 7/4/85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE William P. Jones, MD				TITLE (SPECIFY) MD Deputy			DATE SIGNED 7/4/85	
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.				ADDRESS 695 America Court, Davidsonville, Md. 21035				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-8-85		23c. NAME OF CEMETERY OR CREMATORY Our Lady of the Fields		23d. LOCATION CITY OR TOWN COUNTY STATE Millersville A.A. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS T.A. Hardesty Annapolis Md. 21401				25a. DATE REC'D. BY REGISTRAR JUL 8 1985		25b. REGISTRAR'S SIGNATURE William P. Jones		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____



204019

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies of pages 1 and 2, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR		8 5 REG. NO. 1 8 5 6 4	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruby Hagood Lee		2a. DATE OF DEATH MONTH DAY YEAR July 14, 1985	
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 11, 1924	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee	7b. CITIZEN OF WHAT COUNTRY? USA	6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 60	2b. HOUR A.M.
10 CITY OR TOWN OF DEATH Edgewater	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3006 Solomons Island Road	9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.	
13a. STATE MD	13b. COUNTY A.A.	13c. CITY OR TOWN Edgewater	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary
14 FATHER'S NAME FIRST MIDDLE LAST William Kyle Hagood	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Allie Frazier	12b. KIND OF BUSINESS OR INDUSTRY Board of Education	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 578-32-5322	17. INFORMANT ADDRESS Same as #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung cancer, metastatic DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.			
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from May 26, 1966, to July 14, 1985, that (I) (we) last saw the deceased alive on July 2, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Charles W. Kinzer		22c. DATE SIGNED July 15, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES W. KINZER MD		22e. ADDRESS Annapolis, Maryland	
23a. BURIAL, CREMATION, REMOVAL (CHECK) Cremation	23b. DATE July 15, 1985	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. MD
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD		25a. DATE REC'D. BY REGISTRAR JUL 16 1985	
		25b. REGISTRAR'S SIGNATURE Jana Anderson-Henderson	

MEDICAL CERTIFICATION

2000

204057

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85. 18565

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frederick Jacob Lembke			2a. DATE OF DEATH MONTH DAY YEAR 7 12 85		2b. HOUR MIN. 12:20 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 6, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 92	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS) Retired Truck Farmer	12b. KIND OF BUSINESS OR INDUSTRY Boos Brothers	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY Maryland P.G.		13c. CITY OR TOWN Bowie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 12317 Firtree Lane 20715	
FATHER'S NAME FIRST MIDDLE LAST Henry Lembke		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Febinger			
14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	14b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 102-18-7634	17. INFORMANT ADDRESS 12317 Firtree Lane Arthur F. Lembke (Son) Bowie, Maryland 20715			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Resp. Arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Chronic C-V Dx					Years.
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Cellulitis - ? Arterial Thromb. (4) leg., Supra					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 7/11 , 19 85 , to 7/12 , 19 85 , that (1) (we) last saw the deceased alive on 7/12 , 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.					
22b. SIGNATURE BARRY R. NATHANSON	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/12/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY R. NATHANSON	22e. ADDRESS 51 FRANKLIN ST. ANNAPOLIS 21401				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/15/85	23c. NAME OF CEMETERY OR CREMATORY Cairo Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Cairo Greene New York		
24. FUNERAL DIRECTOR'S NAME Francis Casch's Sons Funeral Home, P.A.			25a. DATE REC'D. BY REGISTRAR JUL 17 1985	25b. REGISTRAR'S SIGNATURE Jane Davidson-Randall	
4739 Baltimore Avenue Hyattsville, Md. 20781					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

703-205

313001

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 5 1 8 5 6 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John Frank LIBERTO			2a. DATE OF DEATH MONTH DAY YEAR July 26, 1985		2b. HOUR 1:23 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2 27 16	6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.		
10. CITY OR TOWN OF DEATH Hanover	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6962 Ridge Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chaueffer	12b. KIND OF BUSINESS OR INDUSTRY Trucking	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY A.A.	13c. CITY OR TOWN Hanover	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II	17. INFORMANT ADDRESS Mary E. Liberto 6962 Ridge Rd. 21076		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lung Cancer & Proven Metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Prolonged Hospitalization & Bedridden State</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION June 85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cerebellar Mass (dilatation of Nucleus)		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/12</u> , 19 <u>85</u> , to <u>7/26</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>7/25</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Robert Burgerman</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-26-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Burgerman, M.D.		22e. ADDRESS University Hospital, Baltimore, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 7/30/85	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.	23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland		
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		ADDRESS 21229 4107 Wilkens Avenue	25a. DATE REC'D. BY REGISTRAR JUL 29 1985	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Carroll County, Maryland
Commissioner of the General Land Office
Baltimore, Maryland

June 22 1882

20 25 28 30 32 34 36 38 40 42 44 46 48 50 52 54 56 58 60 62 64 66 68 70 72 74 76 78 80 82 84 86 88 90 92 94 96 98 100

211020

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 NO. 1856ED7

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DELBERT LLOYD			2a DATE OF DEATH MONTH DAY YEAR JULY 22, 1985		2b HOUR 0749 PM			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 6 23 10		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10 CITY OR TOWN OF DEATH GLEN BURNIE		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Rigger		12b KIND OF BUSINESS OR INDUSTRY Ship Building		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b COUNTY A.A.		13c CITY OR TOWN Pasadena		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Thomas Lloyd			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Williams					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 196-01-1096		17 INFORMANT ADDRESS Catherine Lloyd Same as 13e				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 9041 IMMEDIATE CAUSE (a) Respiratory and Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Septic shock - DUE TO, OR AS A CONSEQUENCE OF (c) COPD - Starvation APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic cardiovascular disease -								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (1) this hospital attended the deceased from January 1980 to July 22-85 that (b) we last saw the deceased alive on 1 19 85 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.								
22b SIGNATURE Renito Martinez		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED July 23-85		
22d PHYSICIAN'S NAME (TYPE OR PRINT) RENITO MARTINEZ, M.D.		22e ADDRESS 2932-A MOUNTAIN RD PASADENA, MD 21122						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 7/26/85		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCATION Balto		
24 FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Hgwy Balto Md		25a DATE REC'D. BY REGISTRAR JUL 26 1985		25b REGISTRAR'S SIGNATURE Robert R. Randle		

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is completed on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "RECEIVED" and "OFFICE" are visible.]

153033

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR **MARGARET A. LLOYD**

REG. NO. **1856 EDE**

1. DECEASED NAME (TYPE OR PRINT) MARGARET A LLOYD			2a. DATE OF DEATH MONTH JULY DAY 2 YEAR 1985		2b. HOUR 620 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH May DAY 1 YEAR 1942		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher	12b. KIND OF BUSINESS OR INDUSTRY Education
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Howard 13c. CITY OR TOWN Columbia			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Path 7068 Winter Rose 21045	
14. FATHER'S NAME FIRST William MIDDLE LAST Loftin		15. MOTHER'S MAIDEN NAME FIRST Christine MIDDLE Heil LAST Williams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 214-40-0582		17. INFORMANT Bertram T. Lloyd ADDRESS Same as # 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Acute respiratory Failure**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Advanced ovarian cancer**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

7 d

16 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

Small Bowel Obstruction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/15 , 19 85 , to 7/2 , 19 85 , that (I) (we) last saw the deceased alive on 7/2 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Long S. Hsu	DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 7-2-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LONG S. HSU	22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 104 GLEN BURNIE, MARYLAND 21061		

23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 7/6/85	23c. NAME OF CEMETERY OR CREMATORY St. Louis Church Cem.	23d. LOCATION CITY OR TOWN Clarksville COUNTY STATE Md.
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24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 5555 Twin Knolls Road, Columbia, Md. 21045	25a. DATE REC'D. BY REGISTRAR JUL 08 1985	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers (pages 1 and 2) and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as being US, show any injury, or other traumatic event, the medical examiner should be notified of choice.

11-2008

Advised on 11/11/08
Auto inspection results

11/11/08
11 months

Some body obstruction

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207087

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 18569

1. DECEASED NAME (TYPE OR PRINT) Charles Edward Lockett Jr.			2a. DATE OF DEATH MONTH DAY YEAR 7 20 85			2b. HOUR 430 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH YEAR 1 5 20		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Foreign Service Office	
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Edward Lockett Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Essie Goodwin		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1938-1945-519-05-8435	
17. INFORMANT NAME Marguerite O. Lockett		17. ADDRESS Same as #13		17. CITY OR TOWN Annapolis		17. STATE MD	

18. CAUSE OF DEATH (Enter only one cause per item 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Damage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>Cardio-respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Infarction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 days 13 days 13 days
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (<u>was</u> hospital) attended the deceased from <u>7/2</u> , 19 <u>85</u> , to <u>7/20</u> , 19 <u>85</u> , that (I) (<u>was</u>) last saw the deceased alive on <u>7/19</u> , 19 <u>85</u> , and that in (my) (<u>own</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>was</u>) (<u>did not</u>) view the body after death.							
22b. SIGNATURE <u>R. I. Hochman, MD</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>7/20/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>R. I. Hochman, MD</u>				22e. ADDRESS <u>16 Murray Ave, Annapolis, Md 21401</u>			

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE July 23, 1985		23c. NAME OF CEMETERY OR CREMATORY Christ Church		23d. LOCATION CITY OR TOWN COUNTY STATE Saluda Middlesex MD	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel-Annapolis, MD				25. DATE REC'D. BY REGISTRAR JUL 22 1985		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
THOMAS		EDWARD		MARKS		, Jr.		JULY 23, 1985		305 AM	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7a. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
Male		White		March 30, 1907		78					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Ohio		United States				ANNE ARUNDEL COUNTY MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
GLEN BURNIE		NORTH ARUNDEL HOSPITAL						Warehouse-man		retired	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. CITY OR TOWN				13b. STREET ADDRESS / ZIP CODE			
13a. STATE				13c. COUNTY				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Maryland				Anne Arundel				Pasadena			
14 FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Thomas E. Marks				Georgia - Cochrane							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)				17. INFORMANT ADDRESS			
NO				233-14-4864				Fern R. Marks / 8438 Maryland Rd. (21122)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE Cause (a) <u>cardio resp. arrest</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic sq. cell Ca.</u>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
NO											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>7-10</u> 19 <u>85</u> , to <u>7-23-85</u> 19 <u>85</u> , that (we) last saw the deceased alive on <u>7-23</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Shobha Reddy</u>						DEGREE <u>MD</u>		22c. DATE SIGNED <u>7-23-85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SHOBHA D. REDDY, M.D.</u>						22e. ADDRESS <u>653 OLD MILL ROAD</u> <u>MILLERSVILLE, MARYLAND 21108</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		July 26, 85		Glen Haven Mem. Cem.		Glen Burnie, Anne Arundel, Md.					
24 FUNERAL DIRECTOR NAME <u>NC Cully Funeral Home/ Pasadena, Md. 21122</u>						25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Jane Davidson-Randall</u>			
						JUL 25 1985					

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8518571

1. DECEASED NAME (TYPE OR PRINT) John McCalley			2a. DATE OF DEATH MONTH DAY YEAR 7-11-85			2b. HOUR 2:24 PM			
1. SEX m		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 6-12-02		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) manager		12b. KIND OF BUSINESS OR INDUSTRY garden shop	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia		13b. COUNTY Arlington		13c. CITY OR TOWN none		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1817 N. Madison St. 22205	
14. FATHER'S NAME FIRST MIDDLE LAST unobtainable				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unobtainable					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II		17. INFORMANT Joni Guane (dau.)		ADDRESS Prestonfield La. Severna Park, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CHF, Metabolic acidosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6-21-85 to 7-11-85 , that (I) (we) last saw the deceased alive on 7-11-85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.									
22b. SIGNATURE D. O. ...				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7-11-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-13-85		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia			
24. FUNERAL DIRECTOR NAME THE ARLINGTON FUNERAL HOME				ADDRESS Arlington, VA		25a. DATE REC'D. BY REGISTRAR JUL 22 1985		25b. REGISTRAR'S SIGNATURE J. Davidson-Rodriguez	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner's report must be notified of once.

218123

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 REG. NO. 18572

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Arthur C. McCormick</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>7/29/85</i>		2b. HOUR <i>9:10 PM</i>
3. SEX <i>Male</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>0-1-29</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>56</i> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>	7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.		
10. CITY OR TOWN OF DEATH <i>Annapolis</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>manager</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>GMAC</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>			13b. COUNTY <i>Anne Arundel</i>	13c. CITY OR TOWN <i>Sovereign Park</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Carl McCormick</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Florence Harris</i>		13e. STREET ADDRESS / ZIP CODE <i>4 Whittier Plwy. 21146</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>YES</i>	16b. SOCIAL SECURITY NO. (# GIVE WAR OR DATES) <i>132-19-2354</i>	17. INFORMANT ADDRESS <i>Nancy McCormick (Same as #13)</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Shock</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hour.</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pericardial heart failure</i>					<i>24 hour</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Ischemic heart disease</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>7/24 1985</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>8 E Vengreen Road Severna Park MD 21146</i>		
22a. I certify that (I) (this hospital) attended the deceased from <i>7/24</i> , 19 <i>85</i> , to <i>7/29</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>7/29</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Gerard Blum</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>7/29/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Gerard Blum</i>		22e. ADDRESS <i>8 E Vengreen Road Severna Park MD 21146</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>	23b. DATE <i>7-30-85</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Westview Crematory</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Westview Balto. MD 21146</i>	23e. DATE REC'D. BY REGISTRAR <i>AUG 02 1985</i>	
24. FUNERAL DIRECTOR NAME <i>Robert Baranco</i>		445 Ritchie Hwy. Severna Park MD 21146		25a. REGISTRAR'S SIGNATURE <i>John F. ...</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMM - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 5 1857EDB
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THOMAS JOHN MCKENNA			2a. DATE OF DEATH MONTH DAY YEAR JULY 06, 1985		2b. HOUR 1036 AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR SEPT. 17, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WELDER	12b. KIND OF BUSINESS OR INDUSTRY BETH. STEEL	
13a. STATE MD.	13b. COUNTY A.A.	13c. CITY OR TOWN GLEN BURNIE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 514 EVELYN AVENUE 21061	
14. FATHER'S NAME FIRST MIDDLE LAST HARRY MCKENNA		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AUGUSTA CARROLL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1927-1936	17. INFORMANT (WIFE) ADDRESS MRS. CECILIA A. MCKENNA SAME AS #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>5 years</u> <u>3 days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22. I certify that (a) (this hospital) attended the deceased from <u>1/06/85</u> to <u>7/06/85</u> that (b) (I) last saw the deceased alive on <u>7/06/85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.					
22a. SIGNATURE <u>Elliott Gorbaty</u>		DEGREE		22b. DATE SIGNED <u>7/07/85</u>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) ELLIOTT GORBATY, M.D.		22d. ADDRESS 7845 OAKWOOD ROAD, SUITE 203 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE JULY 9, 1985	23c. NAME OF CEMETERY OR CREMATORY CATHEDRAL CEMETERY	23d. LOCATION CITY OR TOWN STATE New Castle DELAWARE		
24. FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME GLEN BURNIE, MD. 21061			25a. DATE REC'D. BY REGISTRAR JUL 09 1985	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

203411

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 5 1 8 5 7 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT S MILLER			2a. DATE OF DEATH MONTH DAY YEAR 7 14 85			2b. HOUR 6:18 AM				
1. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 04 10 22		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wilksbarre Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.				
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) manager		12b. KIND OF BUSINESS OR INDUSTRY Car. Tele. Co.		
13a. STATE Md.			13b. COUNTY A.A. Co.		13c. CITY OR TOWN Crownsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1180 Nancy Lane 21032	
14. FATHER'S NAME FIRST MIDDLE LAST Harry H. Cohen			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leonora Peters							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 42-45		17. INFORMANT Marion B. Miller		ADDRESS 1180 Nancy Lane Crownsville, Md.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyoderma Gangrenosa DUE TO, OR AS A CONSEQUENCE OF (b) Clostridium Mutiliforme DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a										
9a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from 19 79 to 2-14 19 85 , that (I) (we) last saw the deceased alive on 7-13 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. SIGNATURE Jon B. Lowe			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 14 July 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jon B. Lowe			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/16/85		23c. NAME OF CEMETERY OR CREMATORY Baldwin Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Millersville, A.A. Md.		
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home			12 Ridgely Ave. ADDRESS			25a. DATE REC'D. BY REGISTRAR 11/18/85		25b. REGISTRAR'S SIGNATURE S. A. Anderson		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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CHIEF IN CHARGE

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

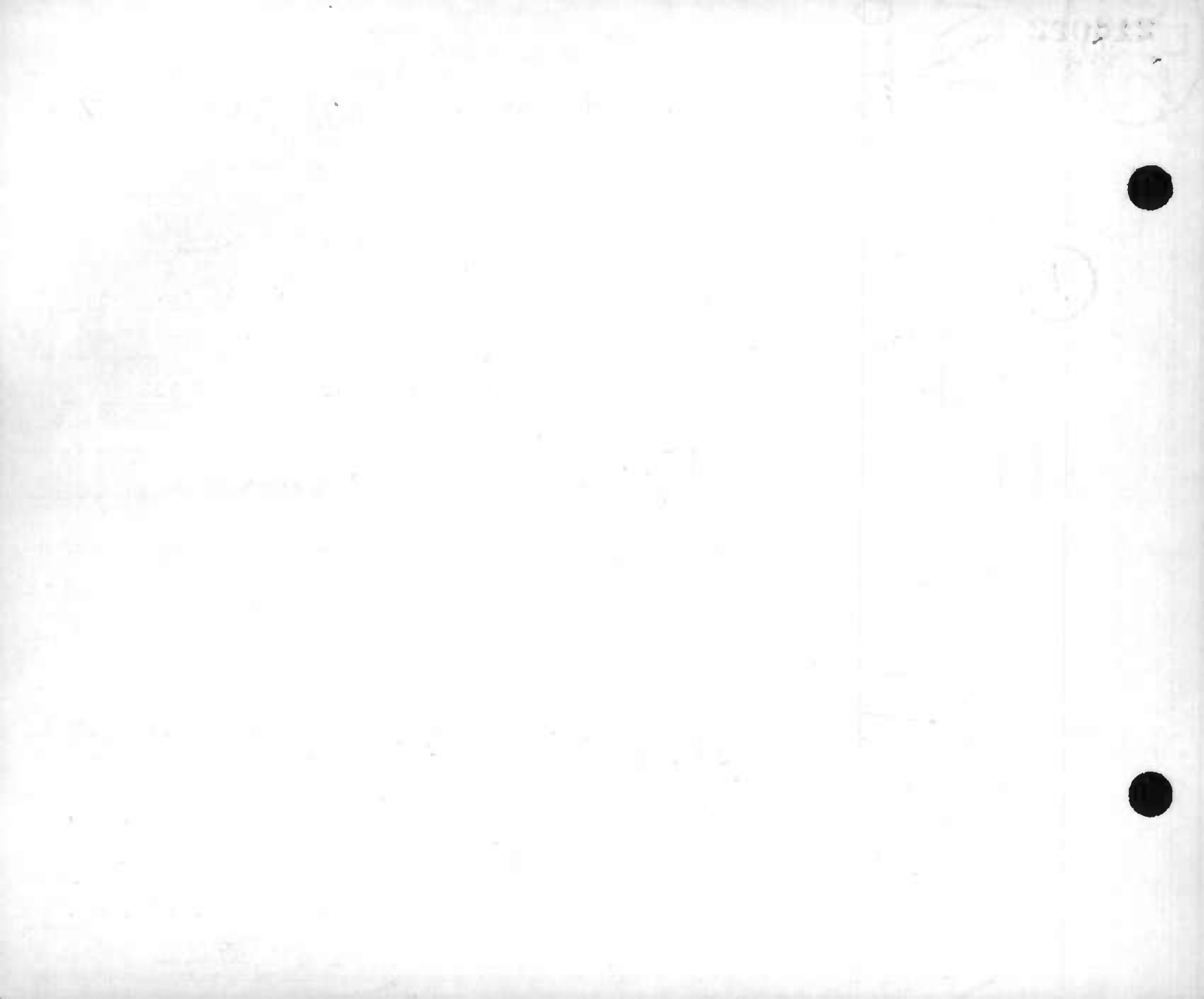
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8518575		
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR					7/20/85		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST					2b. HOUR					4 A.M.		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST					2b. HOUR					4 A.M.		
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. YRS.	
male			caucasian		5 - 29 - 1934			51				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND			U.S.A.					ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
ANNAPOLIS			ANNE ARUNDEL GENERAL HOSPITAL					SECURITY GUARD			HOSPITAL	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
MARYLAND			ANNE ARUNDEL		ANNAPOLIS				3 ARBOR HILL RD. 21403			
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
RUDOLPH S. MILLER					HAZEL GARNER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
YES					215-28-3185		JoAnn S. MILLER SAME AS 13E					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Resp. arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>malignant melanoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> TO DEATH (IF EITHER, FILL IN MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
			P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
						82 7/20 85						
22a. I certify that (1) this hospital's attending physician died from _____ 1982 to 7/20 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (2) (we) (she) (did not) view the body after death.												
22b. SIGNATURE					DEGREE					22c. DATE SIGNED		
WMA Labl										7/24/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS							
DABBS, W.A.					203 GIDDINGS AVE ANNAPOLIS MD.							
23a. BURIAL, CREMATION, REMOVAL			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
BURIAL			7-23-85		CEDAR BLUFF			ANNAPOLIS A.A.CO. MD.				
24. FUNERAL DIRECTOR NAME ADDRESS							25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE					
ROBERT E. EVANS ANNAPOLIS, MARYLAND							JUL 31 1985 [Signature]					

MEDICAL CERTIFICATION



198141

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 5 1 8 5 7 EDT
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GEORGE W MITCHELL			2a. DATE OF DEATH MONTH DAY YEAR JULY 12, 1985		2b. HOUR 0200 PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 20 14		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Chemical	
13a. STATE Maryland			13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Walter Mitchell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ===== Hinkle			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 214-05-2381			17. INFORMANT Mabel E. Mitchell			ADDRESS Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Carcinoma of Lung DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Sang C. DoH</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7-12-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANG C. DOH, M.D.				22e. ADDRESS 95 AQUAHART ROAD GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/15/85		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto A.A. Md			
24. FUNERAL DIRECTOR NAME George J. Gonce				4001 Ritchie Hgwy Balto Md		25a. DATE REC'D. BY REGISTRAR JUL 15 1985		25b. REGISTRAR'S SIGNATURE <i>James H. Anderson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED JUL 1 1964

ALABAMA POWER CO. (INCORPORATED)
NORTH ALABAMA POWER CO. (INCORPORATED)
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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 G. NO. 1 8 5 7 7

1. DECEASED NAME (TYPE OR PRINT) Russell Mitchell			2a. DATE OF DEATH MONTH DAY YEAR 7 16 85			2b. HOUR 538 M				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4 2 97		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.				
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED SUPERV.		12b. KIND OF BUSINESS OR TRAFFIC DEPT.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN SEVERNA PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 504 HEAVYTREE GARTH 21146	
14. FATHER'S NAME FIRST MIDDLE LAST HOWARD MITCHELL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH ENDLEY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WWW-12-2770		17. INFORMANT VIRGINIA MARTIN		ADDRESS 504 HEAVYTREE GARTH SEVERNA PARK, MD 21146			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 6-6 , 19 85 , to 7-16 , 19 85 , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on 7-16 , 19 85 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did not view the body after death.										
22b. PHYSICIAN'S NAME (TYPE OR PRINT) HOWARD GOLDSTEIN					22c. ADDRESS 205 RIDGELY AVE. ANNAPOLIS MD 21401			22d. DATE SIGNED 7/16/85		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE JULY 17, 1985		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE WESTVIEW BALTIMORE MD			
24. FUNERAL DIRECTOR NAME BARRANCO FUNERAL HOME					25a. DATE REC'D. BY REGISTRAR JUL 19 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Rendell			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 NO. 1 8 5 7 8

1. DECEASED NAME (TYPE OR PRINT) ERNEST S. MITZNER			2a. DATE OF DEATH MONTH DAY YEAR 7 18 85		2b. HOUR 9⁴⁰ A.M.	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 6 1 26		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. Co. MD.		
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen'l Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Business Owner		12b. KIND OF BUSINESS OR INDUSTRY Meat Brokerage	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2562 Helaine Hamlet Way (21401)		
14. FATHER'S NAME FIRST MIDDLE LAST ISADORE MITZNER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA GOLDMAN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 074-20-9709		17. INFORMANT ADDRESS Jay Mitzner; 11112 Freas Drive; Gaithersburg, Md 20878		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) (Presumed) Acute Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) atherosclerotic C-V disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 hrs.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes mellitus						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Nov. , 19 83 , to July 18 , 19 85 , that (I) (we) last saw the deceased alive on July 18 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not use the body after death.						
22b. SIGNATURE Barry R. Nathanson		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/18/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY R. NATHANSON		22e. ADDRESS 51 FRANKLIN ST. ANNAP. MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/21/85		23c. NAME OF CEMETERY OR CREMATORY B'Nai Israel Cong. Cemetery; Oxon Hill; P.G.; Md.		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS		ADDRESS 1170 Rockville Pike; Rockville, Md. 20852		25a. DATE REC'D. BY REGISTRAR JUL 24 1985		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 5 7 9

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
CHARLES		HENRY		MOB		RAY, JR.		7		24		1985		0035		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M	B	April 12 1928		57 YRS.						7		24		1985		0035	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
md		U.S.A.		WIDOWED		DIVORCED		A.A.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
ANNAPOLIS		ANNE ARUNDEL Hosp		COOK		U.S. NAVY											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
md		A.A.		ANNAPOLIS		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1993 WEST ST 21401									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Charles		Beverly		Yes		218-16-2493		Delores E. Motray		1993 West ST							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Gastrointestinal Hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
				(b)		Cirrhosis		yrs.									
				(c)		Alcoholism		yrs.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion									
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
James E. Wheeler		Dep		7-24-85													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
James E. Wheeler, M.D.		1116 Gumbottom Road		Crownsville		21032											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)		COUNTY		STATE							
Burial		7-29-1985		md VA Crownsville		Crownsville		A.A.		md							
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
C. Hicks		JUL 26 1985		John Davidson-Randall													

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

2015

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1- FOR
STATE
REGISTRAR

8 REG. NO. 18580

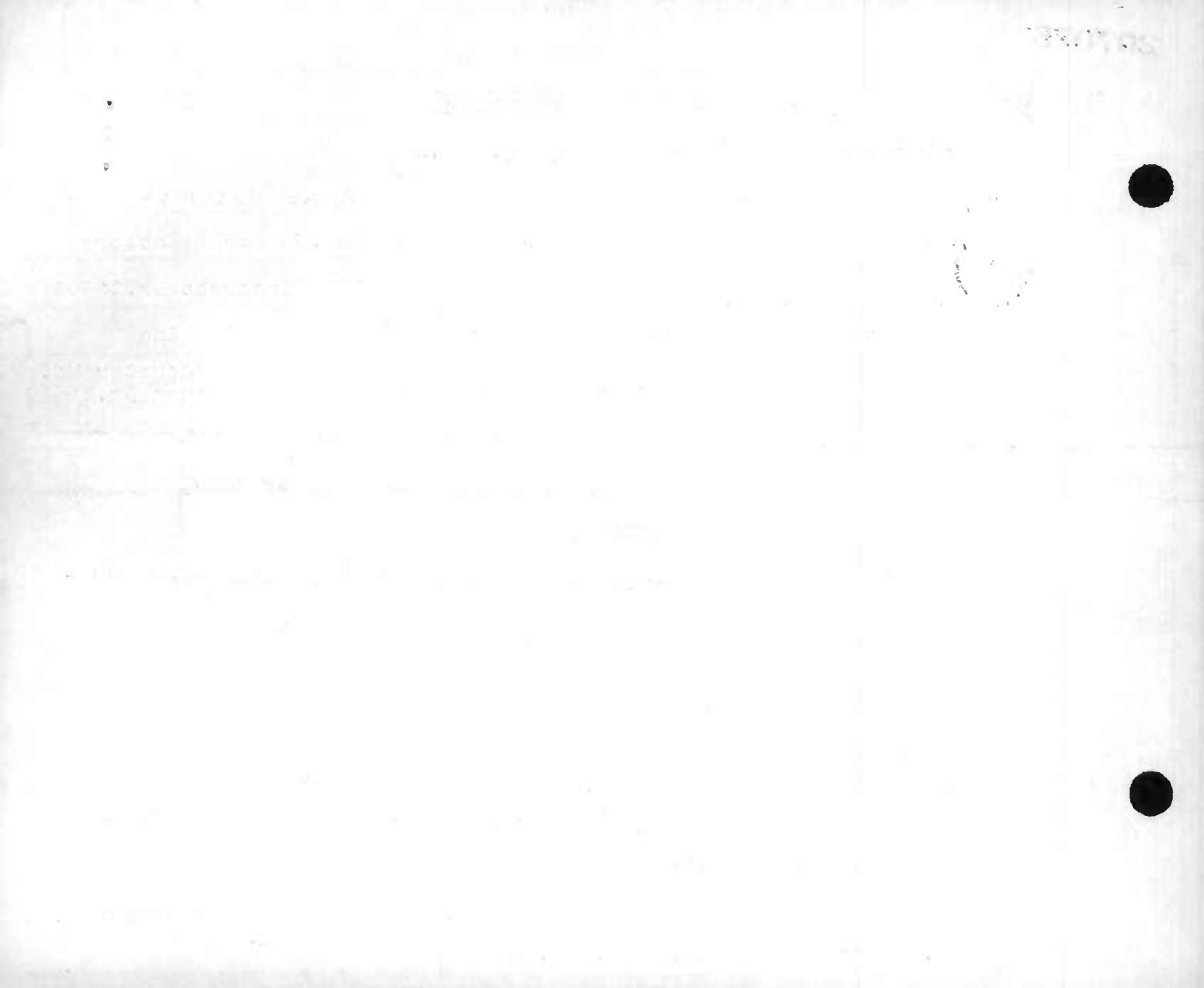
1. DECEASED NAME (TYPE OR PRINT) ROSE Florence MORRONE			2a. DATE OF DEATH MONTH DAY YEAR 7-18-85		7b. HOUR 7:40 AM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 06-08-1944		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) NEW York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Worker	12b. KIND OF BUSINESS OR INDUSTRY Factory
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY A.A. Co.	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Pa'squale Morrone			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenny Gambino		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 075-05-1858		17. INFORMANT ADDRESS Edgewater Md. Gerald Morrone 117 Cardamon Dr. 21037	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Upper Gastrointestinal Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Stress ulceration Severe small/medium vessel Vasculitis DUE TO, OR AS A CONSEQUENCE OF (c) CANDIDAL ERROR					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) CANDIDAL SEPSIS, KLEBSIELLA PNEUMONIA SEPSIS, 3/P BILATERAL AKA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Mary D. Michels M.D.			DEGREE M.D.	22c. DATE SIGNED 7/18/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mary D. Michels M.D.			22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-20-85	23c. NAME OF CEMETERY OR CREMATORY Holy Trinity	23d. LOCATION CITY OR TOWN COUNTY STATE Dunkirk Chautauqua N.Y.		
24. FUNERAL DIRECTOR NAME T.A. Hardesty Annapolis, Md. 21401			25a. DATE REC'D. BY REGISTRAR JUL 22 1985		
			25b. REGISTRAR'S SIGNATURE		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

203107

FOR
STATE
REGISTRAR

85. NO. 18581

1. DECEASED NAME (TYPE OR PRINT) Bessie Hurtt Muhl			2a. DATE OF DEATH MONTH DAY YEAR 7-7-85			2b. HOUR 7:21 PM				
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 4-29-1912		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.				
10. CITY OR TOWN OF DEATH Annapolis, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Q.A.		13c. CITY OR TOWN Stevensville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3 Annapolis View Rd. 21661	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Hilditch				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hilda Hilditch						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-10-6093		17. INFORMANT Daniel L. Muhl		ADDRESS Same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO, OR AS A CONSEQUENCE OF (b) or sepsis DUE TO, OR AS A CONSEQUENCE OF (c) 7798 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION July 5 '85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED chile lithore			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (between _____) (did) (did not) view the body after death.										
22b. SIGNATURE [Signature]				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED [Signature]		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 07/10/85		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County MD			
24. FUNERAL DIRECTOR NAME Tom Helfenbein						ADDRESS Chester, MD 21619		25a. DATE REC'D. BY REGISTRAR JUL 12 1985		
						25b. REGISTRAR'S SIGNATURE [Signature]				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified or called.

159056

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELENA A NEAL					2a. DATE OF DEATH MONTH DAY YEAR 07.11.85		2b. HOUR MIN. 0420		
3. SEX F		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 06 16 06		6. AGE (IN YEARS LAST BIRTHDAY) YRS 79		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH AA MD.			
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AAGH				12a. USUAL OCCUPATION (TYPE WORK, ETC. IF NOT WORKING, GIVE LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY household	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY a.A. Co.		13c. CITY OR TOWN Crownsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1730 Crownsville Rd. 21032	
14. FATHER'S NAME FIRST MIDDLE LAST Max Roden				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Soulyrette					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 883-16-8045		17. INFORMANT ADDRESS Grover T. Neal Jr. P.O. Box 103, Crownsville, Md 21032			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chent, Aortic + Mitral Stenosis, Severe stenosis? COPD</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <u>07.05.85</u> to <u>07.11.85</u> , that (2) I saw the deceased alive on <u>07.10.85</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)									
22b. SIGNATURE DEGREE Michael J. LaPenta MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 07.11.85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL J. LaPENTA MD				22e. ADDRESS 703 GIDDINGS AVE ANNAPOLIS MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/14/85		23c. NAME OF CEMETERY OR CREMATORY Baldwin Mem. U.M.C.		23d. LOCATION CITY OR TOWN COUNTY STATE Millersville, A.A.Co. Md.			
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home				ADDRESS 12 Ridgely Ave Ann. Md. 21401		25a. DATE REC'D. BY REGISTRAR JUL 12 1985			

350032



205009

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP _____
DHMH - 17
(VR A15 ME (5))

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 5 8 3

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		21. HOUR	
EDWARD		S,		NELSON				7		17		19		85				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		22. HOUR	
M	W	10/27/32		52		RS.				7		17		19		85		10:54 A M	
7a. BIRTHPLACE (STATE OR COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Baltimore		U. S. A.				Anne Arundel County													
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Annapolis		Anne Arundel General Hospital		Construction Worker															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md.				Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		1518 E. Clement St.											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Thomas S. Nelson		Emma F. Nelson																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
Yes		Army 316-28-3961		Mary Nelson		1518 E. Clement St.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
		(b)		DUE TO, OR AS A CONSEQUENCE OF															
		(c)		DUE TO, OR AS A CONSEQUENCE OF															
		(d)		DUE TO, OR AS A CONSEQUENCE OF															
		(e)		DUE TO, OR AS A CONSEQUENCE OF															
		(f)		DUE TO, OR AS A CONSEQUENCE OF															
		(g)		DUE TO, OR AS A CONSEQUENCE OF															
		(h)		DUE TO, OR AS A CONSEQUENCE OF															
		(i)		DUE TO, OR AS A CONSEQUENCE OF															
		(j)		DUE TO, OR AS A CONSEQUENCE OF															
		(k)		DUE TO, OR AS A CONSEQUENCE OF															
		(l)		DUE TO, OR AS A CONSEQUENCE OF															
		(m)		DUE TO, OR AS A CONSEQUENCE OF															
		(n)		DUE TO, OR AS A CONSEQUENCE OF															
		(o)		DUE TO, OR AS A CONSEQUENCE OF															
		(p)		DUE TO, OR AS A CONSEQUENCE OF															
		(q)		DUE TO, OR AS A CONSEQUENCE OF															
		(r)		DUE TO, OR AS A CONSEQUENCE OF															
		(s)		DUE TO, OR AS A CONSEQUENCE OF															
		(t)		DUE TO, OR AS A CONSEQUENCE OF															
		(u)		DUE TO, OR AS A CONSEQUENCE OF															
		(v)		DUE TO, OR AS A CONSEQUENCE OF															
		(w)		DUE TO, OR AS A CONSEQUENCE OF															
		(x)		DUE TO, OR AS A CONSEQUENCE OF															
		(y)		DUE TO, OR AS A CONSEQUENCE OF															
		(z)		DUE TO, OR AS A CONSEQUENCE OF															
		(aa)		DUE TO, OR AS A CONSEQUENCE OF															
		(ab)		DUE TO, OR AS A CONSEQUENCE OF															
		(ac)		DUE TO, OR AS A CONSEQUENCE OF															
		(ad)		DUE TO, OR AS A CONSEQUENCE OF															
		(ae)		DUE TO, OR AS A CONSEQUENCE OF															
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		(bh)		DUE TO, OR AS A CONSEQUENCE OF															
		(bi)		DUE TO, OR AS A CONSEQUENCE OF															
		(bj)		DUE TO, OR AS A CONSEQUENCE OF															
		(bk)		DUE TO, OR AS A CONSEQUENCE OF															
		(bl)		DUE TO, OR AS A CONSEQUENCE OF															
		(bm)		DUE TO, OR AS A CONSEQUENCE OF															
		(bn)		DUE TO, OR AS A CONSEQUENCE OF															
		(bo)		DUE TO, OR AS A CONSEQUENCE OF															
		(bp)		DUE TO, OR AS A CONSEQUENCE OF															
		(bq)		DUE TO, OR AS A CONSEQUENCE OF															
		(br)		DUE TO, OR AS A CONSEQUENCE OF															
		(bs)		DUE TO, OR AS A CONSEQUENCE OF															
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		(ca)		DUE TO, OR AS A CONSEQUENCE OF															
		(cb)		DUE TO, OR AS A CONSEQUENCE OF															
		(cc)		DUE TO, OR AS A CONSEQUENCE OF															
		(cd)		DUE TO, OR AS A CONSEQUENCE OF															
		(ce)		DUE TO, OR AS A CONSEQUENCE OF															
		(cf)		DUE TO, OR AS A CONSEQUENCE OF															
		(cg)		DUE TO, OR AS A CONSEQUENCE OF															
		(ch)		DUE TO, OR AS A CONSEQUENCE OF															
		(ci)		DUE TO, OR AS A CONSEQUENCE OF															
		(cj)		DUE TO, OR AS A CONSEQUENCE OF															
		(ck)		DUE TO, OR AS A CONSEQUENCE OF															
		(cl)		DUE TO, OR AS A CONSEQUENCE OF															
		(cm)		DUE TO, OR AS A CONSEQUENCE OF															
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		(co)		DUE TO, OR AS A CONSEQUENCE OF															
		(cp)		DUE TO, OR AS A CONSEQUENCE OF															
		(cq)		DUE TO, OR AS A CONSEQUENCE OF															
		(cr)		DUE TO, OR AS A CONSEQUENCE OF															
		(cs)		DUE TO, OR AS A CONSEQUENCE OF															
		(ct)		DUE TO, OR AS A CONSEQUENCE OF															
		(cu)		DUE TO, OR AS A CONSEQUENCE OF															

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WILKINSON
DODGE

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

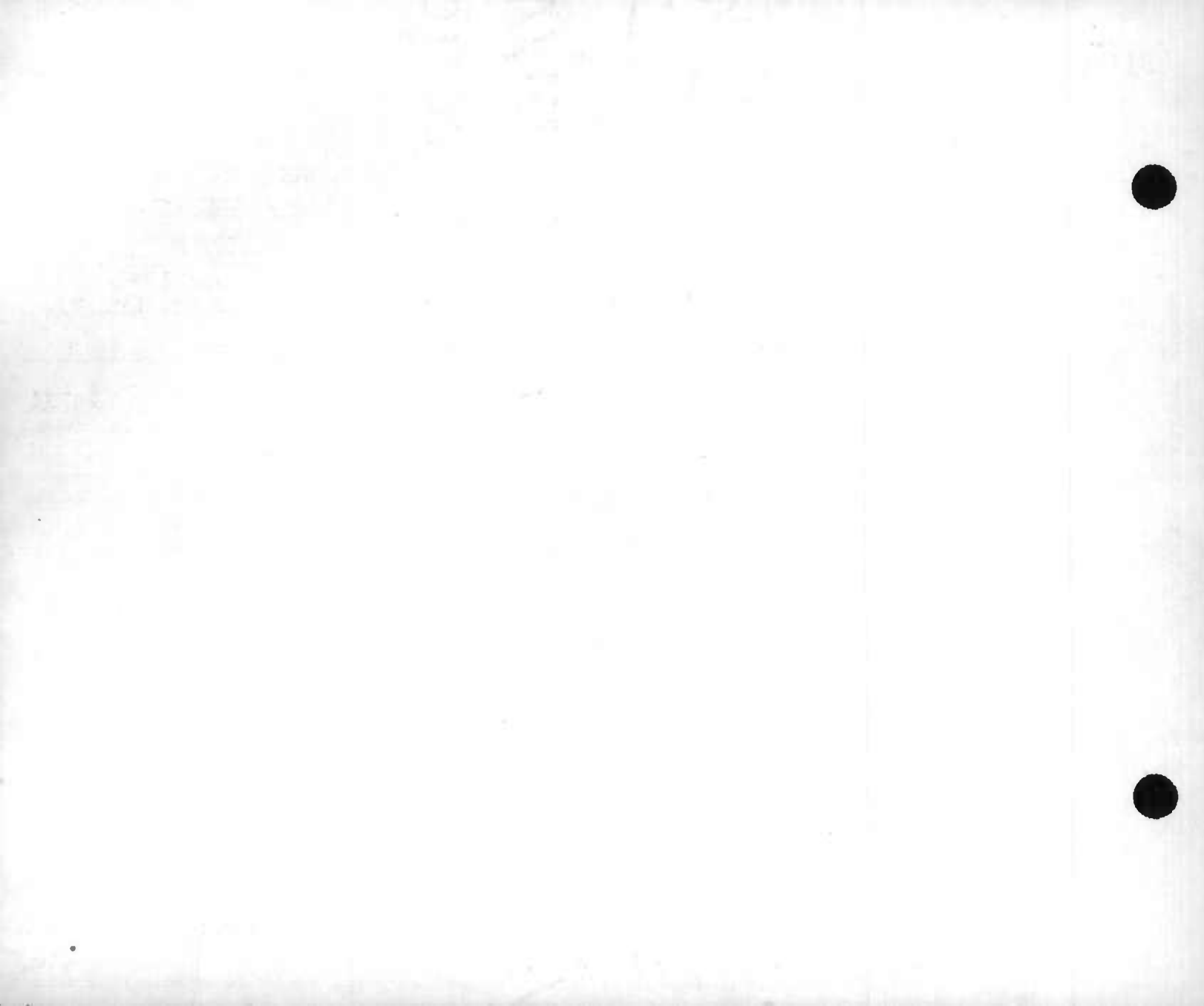
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 REG. NO. 185874

1. DECEASED NAME (TYPE OR PRINT) MARGARET HARRIS NIXON			2a. DATE OF DEATH MONTH DAY YEAR JULY 23, 1985		2b. HOUR 6:56 AM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 12 20 1916		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Warrenton, N.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Balto., City Govt.	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY AA.Co.	13c. CITY OR TOWN Glenburnie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Bravid W. Harris		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Burgess		13e. STREET ADDRESS / ZIP CODE 7369 E. Furnace Br. Rd. 21061	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. no		17. INFORMANT ADDRESS Mr. Sumner Nixon 7887 Rose La. 20794	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pharyngeal Cancer, Pm DUE TO, OR AS A CONSEQUENCE OF (b) Dysphagia DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 7/23 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE H. T. ...		DEGREE ATTENDING PHYSICIAN MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD TOWHIDIAN, M.D.		22e. ADDRESS 3236 MOUNTAIN ROAD PASADENA, MARYLAND 21122			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/26 85	23c. NAME OF CEMETERY OR CREMATORY Arbutus		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.
24. FUNERAL DIRECTOR NAME James H. ...			ADDRESS ...		25a. DATE REC'D. BY REGISTRAR JUL 24 1985

BP _____



210013

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1- FOR
STATE
REGISTRAR

8 5 REG. NO. 1 8 5 8 5

1. DECEASED NAME (TYPE OR PRINT) Josephine SPEIDEN			LAST NOONE			2a. DATE OF DEATH MONTH DAY YEAR July 12 1985			2b. HOUR 6:00 A.M.		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 5 5 31			6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 54		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.		
10. CITY OR TOWN OF DEATH Fairhaven			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6614 REVELL Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY A.A.			13c. CITY OR TOWN Fairhaven			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS 6614 REVELL Rd.			14. FATHER'S NAME FIRST MIDDLE LAST Robert SPEIDEN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE HELEN GIBBS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Catherine Noone			SAME AS # 13 above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic esophageal cancer DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from OCTOBER , 19 77 , to July , 19 85 , that (I) (we) last saw the deceased alive on July 9 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Elizabeth Anne Spitzer						DEGREE MD			22c. DATE SIGNED 7-12-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Elizabeth Anne Spitzer						22e. ADDRESS 19 Chesapeake Beach Road East Owings Md. 20736					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE July 15 1985			23c. NAME OF CEMETERY OR CREMATORY MD. VETERANS CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE CHELTENHAM CHARLES, MD		
24. FUNERAL DIRECTOR NAME RAUSCH FUNERAL Home						ADDRESS OWINGS MD			25a. DATE REC'D BY REGISTRAR JUL 19 1985		
						25b. REGISTRAR'S SIGNATURE John Davidson-Randall					

BP

0.100.12

213141

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 REG. NO. 1 8 5 8 6

1. DECEASED NAME (TYPE OR PRINT) Rachel Blanche Overson			2a. DATE OF DEATH MONTH DAY YEAR July 28, 1985		2b. HOUR 1:50 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 5 1921		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY A.A. Co.	13c. CITY OR TOWN Pasadena	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 21122 18 Little Mission Ct.
14. FATHER'S NAME FIRST MIDDLE LAST John Rhoades			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lola Jones		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) XXXXXXXXXX		17. INFORMANT ADDRESS Same Wayne A. Overson (Husband) as 13	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE a) Superior mesenteric artery thrombosis b) Necrosis of small & large intestine c) Atherosclerotic vascular disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few days few days years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Hypertension, many years of heavy smoking					
19a. DATE OF OPERATION 7/24/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from 7/24/85, 19, to 7/28/85, 19, that (1) (we) last saw the deceased alive on 7/27/85, 19, and that (1) (my) (last) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (not) view the body after death.					
22b. SIGNATURE Wm A Cassidy		DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/29/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm. A. Cassidy, MD		22e. ADDRESS 2510 RIVA ROAD, Ste 222 Annapolis, MD - 21401			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 31 July 1985	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Men.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD.	
24. FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie, MD		25a. DATE REC'D. BY REGISTRAR JUL 30 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Specimen number 111218 is a very
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 REG. NO. 1 8 5 8 7

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eleanor G. Owings			2a. DATE OF DEATH MONTH DAY YEAR July 20, 1985		2b. HOUR P. M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb 8, 1905		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 80	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co., MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Annapolis Convalescent Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Rel. office clerk		12b. KIND OF BUSINESS OR INDUSTRY A.A.Co.
13a. STATE MD	13b. COUNTY AA	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 21401 202 Duke of Gloucester St	
14. FATHER'S NAME FIRST MIDDLE LAST Clifford Owings		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Hartge			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-365421		17. INFORMANT ADDRESS Frances V.N. Owings - Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 575 58 7/20 85	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 _____, to _____, 19 _____, that (I) (we) last saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Richard Teeler</i>				22c. DATE SIGNED 7/22/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Teeler, MD				22e. ADDRESS Franklin Street Annapolis, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE July 22, 1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
23d. LOCATION CITY OR TOWN Southland		23e. COUNTY P.G.		23f. STATE MD	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD				25. DATE REC'D. BY REGISTRAR JUL 22 1985	
				25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

203522

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 5 8 8

1. DECEASED NAME (TYPE OR PRINT) Norman T. Reddicord, Jr.			2a. DATE KNOWN OF DEATH 7 16 1985			2b. HOUR 0940		
3. SEX m	4. RACE Cau	5. DATE OF BIRTH MONTH DAY YEAR 01 02 24 61	6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 7 16 1985		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel		
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman -- Lever Brothers		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. CITY OR TOWN Anne Arundel		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 7978 Phirne Road 21061	
14. FATHER'S NAME FIRST MIDDLE LAST Norman T. Reddicord, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Lovell			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		
16b. SOCIAL SECURITY NO. WW II			17. INFORMANT Marie Hager			17. ADDRESS 2529 McComas Ave. Balto., MD. 21222		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. ASCVD (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2-OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. Hypertension, Diabetes Mellitus								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE William P. Jones, M.D.			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.			ADDRESS 695 America Ort., Davidsonville, Md. 21035					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/19/1985		23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.			25a. DATE REC'D. BY REGISTRAR JUL 18 1985			25b. REGISTRAR'S SIGNATURE William P. Jones		
7922 Wise Avenue			Dundalk, Maryland 21222					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE REASON FOR DELAY IN ITEM 18. THIS CERTIFICATE, PAGE 4, SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM #M-3, PAGE 5, FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

 DHMH - 17
 (VR A15 ME (5))
 20M 4/82

200072

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 REG. NO. 18589

1. DECEASED NAME (TYPE OR PRINT) BERNADETTE E. PETERSON			2a. DATE OF DEATH MONTH DAY YEAR 7-7-85		2b. HOUR MIN. 6:45 M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 9 34		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CALIFORNIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL CO. MD.		
10. CITY OR TOWN OF DEATH MILLERSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1022 RUSTLING OAKS DRIVE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE Maryland		13b. COUNTY A.A. County	13c. CITY OR TOWN MILLERSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT A CLARK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY GRIFFIN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 570-42-4787		17. INFORMANT ADDRESS CHARLES A. PETERSON (Same as #13)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma of breast DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 6-28 , 19 85 , to 7-7 , 19 85 , that (I) (we) lost saw the deceased alive on 7-6 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE LARRY T. O'HERLIHY MD		DEGREE MD		22c. DATE SIGNED 7-7-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LARRY T. O'HERLIHY MD		22e. ADDRESS 325 Hospital Drive, Germantown MD 20861				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 7-9-85		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW CREMATORY		
24. FUNERAL DIRECTOR NAME ROBERT BARRANCO		ADDRESS 495 Ritchie Hwy Severna Park, MD 21144		25a. John A. O'Connell		
23d. LOCATION CITY OR TOWN COUNTY STATE WESTVIEW BALTIMORE MD		25b. John A. O'Connell				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

10

CHIEFMAN

15

ALBERT A. C. 1947
WILLERVILLE 1033 KISTLER AND DRIVE HADENWIESE HOME
CALIFORNIA N-2-A
Y
11 8 34
E. PETTERSON
7-1-1946

Robert B. B. 1947
11 8 34
7-1-1946

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

214043

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 5 REG. NO. 1 8 5 9 0							
1. DECEASED NAME (TYPE OR PRINT) <i>Marie A. Plattner</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>7/24/85</i>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 9 1993</i>		6. AGE (IN YEARS, LAST BIRTHDAY) <i>91</i>		7b. HOUR <i>1730</i>	
7a. BIRTHPLACE COUNTRY <i>MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>ANNE ARUNDEL MD.</i>			
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>575 COOVER RD.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD.</i>		13b. COUNTY <i>US</i>		13c. CITY OR TOWN <i>Annapolis</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>575 COOVER RD 21401</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>FRANCIS B. NOLKER</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARY H. SPIKER</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>212 16 2447</i>		17. INFORMANT ADDRESS <i>CATHERINE HODGES #13</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer head of pancreas</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastatic disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Sub dural hematoma 7 years ago</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>no operation</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <i>no accident</i>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>6/24/85</i> to <i>7/24/85</i> , that (I) (we) last saw the deceased alive on <i>7/24/85</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Charles H. Wirth MD</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>7/24/85</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Charles H. Wirth MD</i>		22e. ADDRESS <i>Lothian Md</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>7/25/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>CURRACY OF FIELD</i>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <i>MILLERSVILLE AIA MD</i>			
24. FUNERAL DIRECTOR NAME <i>Taylor Funeral Chapel</i>		ADDRESS <i>Annapolis, MD.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUL 31 1985</i>		25b. REGISTRAR'S SIGNATURE <i>John Jackson</i>			

2

206111

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be placed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMMA NONE PORTEE						2a. DATE OF DEATH MONTH DAY YEAR JULY 22, 1985		2b. HOUR MIN. 0510 AM	
3 SEX Female		4 RACE B		5. DATE OF BIRTH MONTH DAY YEAR Feb 4 1905		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md		13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES STANSBURY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NETTIE LITTLE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Unknown		17. INFORMANT ADDRESS JAMES ANDERSON-187 Brownswood Rd. Anna. Md. 21401					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Stroke</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/18</u> , 19 <u>85</u> , to <u>7/22</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased expire on <u>7/21</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>7/22/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. M. GAYOSO				22e. ADDRESS 5411 OLD FREDERICK ROAD BALTIMORE, MARYLAND 21229					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-25-1985		23c. NAME OF CEMETERY OR CREMATORY Asbury Broadneck		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Md			
24. FUNERAL DIRECTOR NAME C.E. Hicks 111 1922 Forest Drive				ADDRESS Annapolis, Md		25a. DATE REC'D. BY REGISTRAR JUL 22 1985		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP

111303



111303

213053

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 5 9 2

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		X MONTH		DAY		YEAR		21. HOUR							
Tracey Ann Price								7/ 25/19 85								A M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		21. HOUR			
Female		Caucasian		June 10, 1965		20 YRS.						7/ 25/19 85								A M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland				USA								Anne Arundel County, MD											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Ft. Meade				Kimbrough Army Hospital								Bank Teller				Banking							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																21054							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS															
Maryland		Anne Arundel		Gambrills		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2238 Autumn Valley Circle															
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST								FIRST MIDDLE LAST															
Everett D. Price, Jr.								Francine V. Granati															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS											
NO				215-96-8943				Francine V. Price				2238 Autumn Valley Cir. Gambrills, MD 21054											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																							
PART I DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) Multiple Injuries																							
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																							
(b) DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?											
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
11:30 PM 7/24/1985				subj. passenger in auto/lost control/ejected																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN				COUNTY				STATE			
roadway				Dairy Farm Rd.,				Gambrills,				Anne Arundel,				Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER								DATE SIGNED				7/26/85							
EXAMINER'S NAME (TYPE OR PRINT)				Gregory R. Kauffman, M.D.								ADDRESS				111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN				COUNTY				STATE			
Cremation				July 29, 1985				Metropolitan Crematory				Alexandria, Fairfax,				Virginia							
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR								25b. REGISTRAR'S SIGNATURE											
Beall Funeral Home				16000 Annapolis Road Bowie, MD 20715-3043								JUL 30 1985				John Davidson							

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

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WASHINGTON, D.C. 20540

U.S.

OFFICE

Banking

Bank of America

1000 Wisconsin Avenue, N.W.

Washington, D.C.

2000 Pennsylvania Avenue, N.W.

Washington, D.C.

Branch

Branch

Branch

Branch

2000 Wisconsin Avenue, N.W.

Washington, D.C.

2000 Pennsylvania Avenue, N.W.

NO



SECTION

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U.S. DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20540
OFFICE OF THE ASSISTANT SECRETARY
FOR TECHNICAL ASSISTANCE
AND ECONOMIC DEVELOPMENT
TECHNICAL ASSISTANCE
AND ECONOMIC DEVELOPMENT
TECHNICAL ASSISTANCE
AND ECONOMIC DEVELOPMENT

199058

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Edward			MIDDLE Joseph			LAST Prokop			20. DATE KNOWN OF DEATH ESTI- MATED		X MONTH 7		DAY 8		YEAR 1985		21. HOUR M 12:50	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 4 20 26		6. AGE (IN YEARS) (LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		22. DATE PRONOUNCED DEAD		MONTH 7		DAY 8		YEAR 1985		23. HOUR P.M. 12:50	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD									
10. CITY OR TOWN OF DEATH Crofton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1703 Fallsway Drive								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER				12b. KIND OF BUSINESS OR INDUSTRY NASA					
13a. STATE md.				13b. COUNTY A.A.Co				13c. CITY OR TOWN Crofton				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1703 Fallsway Dr 21114							
14. FATHER'S NAME FIRST MIDDLE LAST John Prokop										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agusta UNKNOWN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 44-46				17. INFORMANT 119-16-7730				ADDRESS MAFALDA Prokop #13e									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u> (rifle) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-lying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:45xx 7 8 1985				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self inflicted													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1703 Fallsway Drive, Crofton, A.A. Co, Md.													
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE 										TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 7/9/85			
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.										ADDRESS 111 Penn St. Balto.MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 7/10/85				23c. NAME OF CEMETERY OR CREMATORY Westview PARK				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD									
24. FUNERAL DIRECTOR NAME T. A. Hardesty										ADDRESS Annapolis Md. 20701				25a. DATE REC'D. BY REGISTRAR JUL 12 1985				25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 (this) should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 1 8 5 9 4			
1. FOR STATE REGISTRAR John William Rau				2a. DATE OF DEATH MONTH DAY YEAR 7/23/85			
1. DECEASED NAME (LAST, FIRST, MIDDLE) John William Rau				2b. HOUR 8:30 P.M.			
1. SEX MALE		2. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3 27 28		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Superintendent		12b. KIND OF BUSINESS OR INDUSTRY Insurance	
13a. STATE Maryland				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Severna Park	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 194 Fulbright Court 21146			
14. FATHER'S NAME FIRST MIDDLE LAST Harry Nelson Rau				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie V. Jaretsky			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Nancy Rau same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from January 19 85, to 7/23 19 85, that (I) (we) last saw the deceased alive on 7/23 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.							
22a. PHYSICIAN'S NAME (TYPE OR PRINT) Franklin & Cathedral Streets Annap., MD				22b. ADDRESS		22c. DATE SIGNED 7/23/85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 7/25/1985		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland	
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley, Inc. Balto., MD 21222				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 25 1985 [Signature]			

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WITBAMIN

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 REG. NO. 18595

1. DECEASED NAME FIRST <i>Frances</i> MIDDLE LAST <i>Rawlings</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>7-30-85</i>		2b. HOUR <i>9.30P</i> AM
3. SEX <i>F</i>	4. RACE <i>B</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>9 28 1898</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALCO</i> MD.		
10. CITY OR TOWN OF DEATH <i>Gambrells</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN HOSPITAL, CITY, STREET ADDRESS) <i>2540 Brickhead Road</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MAJORITY OF WORKING LIFE) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i>			13b. COUNTY <i>BALCO</i>	13c. CITY OR TOWN <i>Gambrells</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Fletcher Queen</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elia Queen</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>219-32--1745</i>	17. INFORMANT ADDRESS <i>William T. Ridgely 2540 Brickhead RD Gambrells, Md</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCUS</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 14</i> 19 <i>1975</i> , to <i>7-30</i> 19 <i>85</i> , that (I) (we) lost saw the deceased alive on <i>7-28-85</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Errol A. Phillips</i>		22c. DATE SIGNED <i>7-31-85</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ERROL A. Phillips MD</i>	
22e. ADDRESS <i>1835 Forest Drive Annapolis, MD</i>		22f. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE) <i>Aug 7 1985</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8/3/85</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt Taber Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Annapolis, Md</i>
24. FUNERAL DIRECTOR NAME <i>William Reese and Sons Mrtys</i>			25. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE) <i>Aug 7 1985</i>		

BP
DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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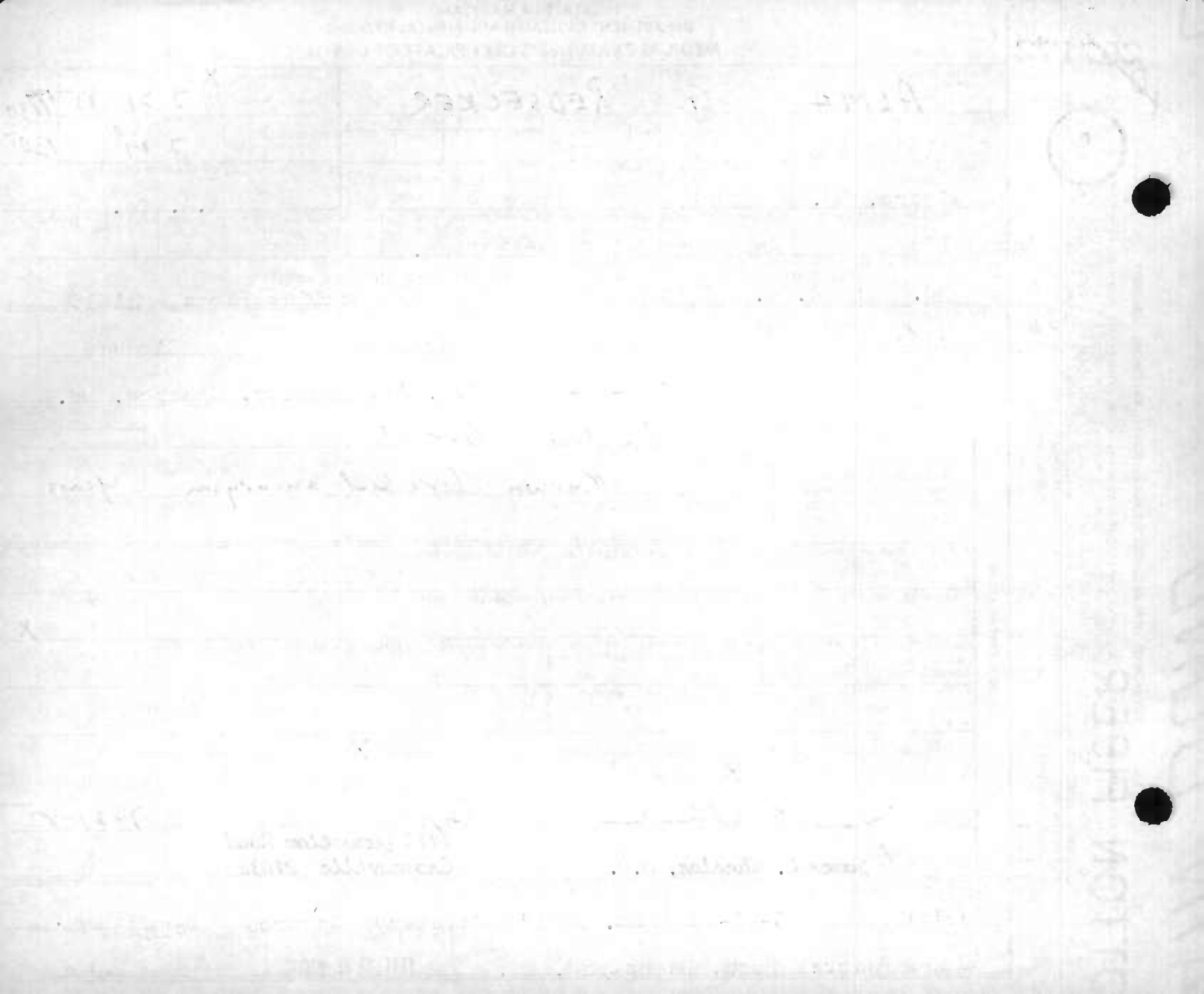
FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 5 9 6

1. DECEASED NAME (TYPE OR PRINT) ALMA		FIRST G.		MIDDLE REDSECKER		LAST		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7 21 19 85		2b. HOUR 1730	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 5 DAY 30 YEAR 13	6. AGE (IN YEARS) LAST BIRTHDAY 72 YRS.	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	7c. DATE PRONOUNCED DEAD 7 21 19	2d. HOUR 1305		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. Co. MD.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HWF		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. CITY OR TOWN A. A.		13c. CITY OR TOWN Chester		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Marling Farms 21619			
14. FATHER'S NAME FIRST Herbert MIDDLE Keiser LAST Gertrude				15. MOTHER'S MAIDEN NAME FIRST Gertrude MIDDLE Sigmund LAST Sigmund							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218218-8378		17. INFORMANT ADDRESS Mrs. Ann Boerner, Upperco, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. Known cerebral aneurysm (b) Known cerebral aneurysm DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE James E. Wheeler				TITLE (SPECIFY) Dep				DATE SIGNED 2-21-85			
EXAMINER'S NAME (TYPE OR PRINT) James E. Wheeler, M.D.				ADDRESS 1116 Gumbottom Road Crownsville 21032							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-25-85		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery Upperco				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. ADDRESS				25a. DATE REC'D. BY REGISTRAR JUL 24 1985		25b. REGISTRAR'S SIGNATURE G. Davidson-Randall					

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



206082

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10M 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8597	
1. DECEASED NAME (TYPE OR PRINT)		FIRST RONALD		MIDDLE EUGENE		LAST REINHOLD		2a. DATE KNOWN OF DEATH		MONTH 19 DAY 7 YEAR 85	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2b. DATE PRONOUNCED DEAD	
M	CAU	12 20 33		51 YRS.		MONTHS DAYS		HOURS MIN.		19 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania		U.S.A.				Ann Arundel County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS	
Glen Burnie		North Arundel						Maintenance - Yorktown		Paper Co	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
PA		City		York		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17404 313 N. Newberry St.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
James Reinhold				Beatrice Myers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO				177-26-6357		Heffner Funeral Home, York, Pa. 17404					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a)											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
Leukemia											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
										YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
William P. Jones, M.D.				DEPUTY				7/20/85			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
William P. Jones, M.D.				695 America Crt., Davidsonville, Md. 21035							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial		7-23-85		Prospect Hill Cemetery				Manchester Township, York, Pa.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
NAME Ruck Towson Funeral Home, Inc. 1050 York Rd. 21204				JUL 22 1985				John Davidson-Ruck			

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190058

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR		REG. NO. 8598	
1. DECEASED NAME (TYPE OR PRINT) Rabbi Morris D Rosenblatt		2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 29 1985	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR FEB. 9, 1913	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RABBI
13a. STATE MARYLAND		13b. CITY OR TOWN ANN APOLIS	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM DAVID ROSENBLATT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FEIGE MILLER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. ANNAPOLIS, MD. #21403	
17. INFORMANT ADDRESS MRS. ESTHER ROSENBLATT 193 HILLTOP LANE		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8147 IMMEDIATE CAUSE (a) Cranio cerebral and cervical trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR 9:30 MONTH DAY YEAR 6 29 1985	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by auto			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE Spa Rd & Hilltop Lane, Annapolis, A.A.CO, MD.			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
ACTUAL SIGNATURE Thomas D. Smith		TITLE (SPECIFY) M.D. Acting Chief	
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.		DATE SIGNED 6/30/85	
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 6/30/85	
23c. NAME OF CEMETERY OR CREMATORY KNESSETH ISRAEL CEM		23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS, ARUNDEL, MD.	
24. FUNERAL DIRECTOR NAME SOE LEVINSON & BROS.		25a. DATE REC'D. BY REGISTRAR JUL 05 1985	
25b. REGISTRAR'S SIGNATURE John Davidson			

214042

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 18599

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST ELEANOR M ROWELL		2a. DATE OF DEATH MONTH DAY YEAR 7-23-85		2b. HOUR 5:45 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 1, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 13 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cryptographer		12b. KIND OF BUSINESS OR INDUSTRY Civil Service	
13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ernest A. Rowell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha E. Philbrook		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-32-5405	
17. INFORMANT ADDRESS R.F.D. 6, Box 683 Augusta, ME 04330		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE PULMONARY DIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 10 YRS		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I RHEUMATIC VALVULAR HEART DISEASE, OCELLITIS OF LEG			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-18-85 to 7-23-85, that (I) (we) last saw the deceased alive on 7-23-85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
22b. SIGNATURE Edward S. Beck, MD		22c. DATE SIGNED 7/24/85		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward S. Beck, MD		22e. ADDRESS 11616 Forest Drive, Annapolis, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE July 26, 1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. MD	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel-Annapolis, MD		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR JUL 31 1985		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

(2)

1. The first part of the report is a general description of the area. It is a small, flat, open area with a few scattered trees and shrubs. The soil is sandy and the vegetation is sparse. The area is located in the north-east corner of the plot.

2. The second part of the report is a detailed description of the vegetation. It is a list of the plants found in the area, including their names, heights, and other characteristics. The plants are listed in alphabetical order.

3. The third part of the report is a description of the soil. It is a sandy soil with a high pH and low organic matter content. The soil is described as being "very sandy" and "very dry".

4. The fourth part of the report is a description of the climate. It is a hot, dry climate with high temperatures and low humidity. The climate is described as being "very hot" and "very dry".

5. The fifth part of the report is a description of the water resources. There are no permanent water resources in the area, but there are a few small, temporary pools of water that form after heavy rain.

6. The sixth part of the report is a description of the wildlife. There are no large mammals in the area, but there are a few small birds and insects.

7. The seventh part of the report is a description of the human population. There are no permanent human settlements in the area, but there are a few small, temporary camps that are used by nomads.

8. The eighth part of the report is a description of the land use. The land is used for grazing by nomads and for the collection of wild plants and animals.

9. The ninth part of the report is a description of the conservation status. The area is considered to be of high conservation value due to its unique vegetation and wildlife.

10. The tenth part of the report is a description of the management plan. The plan is to protect the area and its resources, and to provide for the needs of the local population.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 7, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 900. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8600									
1. DECEASED NAME (TYPE OR PRINT)										FIRST MIDDLE LAST										7a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR					
Mathias R. Ruppert																				7		7		1985		M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR													
Male		White		11 23 23		61 YRS.						7		8		1985		1730 M											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				MD.													
Maryland				U.S.A.								Anne Arundel																	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore				100 15th Avenue (Home)								Electrician				Ship Bldg.													
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET ADDRESS									
13a. STATE Maryland										13b. COUNTY Anne Arundel										13c. CITY OR TOWN Baltimore									
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																			
FIRST MIDDLE LAST										FIRST MIDDLE LAST																			
Louis J. Ruppert										Catherine Raymer																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS																	
Yes				WW II				216-16-6090				Catherine Walker				1515 Hanover St Balto Md													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) Cardiac Arrest																													
DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																													
(b) A.S.C.U.O.																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																													
Hypertension, Diabetes, Ethanol Abuse																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?									
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
					P.M. 19																								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION					CITY OR TOWN STATE														
										STREET																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																													
ACTUAL SIGNATURE William P. Jones, M.D.										TITLE (SPECIFY) Deputy MEDICAL EXAMINER										DATE SIGNED 7/9/85									
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN				COUNTY STATE									
Burial										7/11/85		Meadowridge Mem Park				Baltimore				Howard Md									
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
George J. Gonce										4001 Ritchie Hgwy Balto Md										JUL 12 1985									

1992

Page 15

204022

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 4 and 5, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of date.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 85 18601							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
CARL		Purvis		RUSSELL				7-11-85	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Male		CAUC.		12-18-05		79 YRS.		4:35 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Anne Arundel Co., MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							
Crownsville		Fairfield Nursing Center							
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Retired		Dentist							
13a. USUAL RESIDENCE 1 IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13. STREET ADDRESS / ZIP CODE	
MD		AA		Crownsville				21032	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
John T Russell		Annie MEH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		214-38-3681		John T. Russell		11 Eastern Ave. Annapolis, MD 21403			
18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a).		DUE TO, OR AS A CONSEQUENCE OF (b).		DUE TO, OR AS A CONSEQUENCE OF (c).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Pneumonitis		Severe general deterioration		DEMENTIA, profound of the →		21 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						1 year			
						5+ years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.									
Alzheimer Type									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. certify that (I) (the hospital) attended the deceased from 6/12/85 to Present, 1985, that (I) last saw the deceased alive on 6/12/85 and that in (my) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
Peter F. Verkoum		MD						7/12/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
PETER F. VERKOUW MD		1033 Forest Dr. Annapolis, Md, 21401							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		July 15, 1985		St Anne's		Annapolis AA MD			
24. FUNERAL DIRECTOR NAME		24e. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Taylor Funeral Chapel - Annapolis, MD				JUL 16 1985		Gina Anderson-Henderson			

MEDICAL CERTIFICATION

212005

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 18602

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) ROBERT C. RUSSELL			2a DATE OF DEATH MONTH DAY YEAR 7-23-85		2b HOUR 10²⁷ AM						
3 SEX MALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JUNE 29 1926		6. AGE (IN YEARS (LAST BIRTHDAY)) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MAINE		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.					
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAINTENANCE		12b. KIND OF BUSINESS OR INDUSTRY B.O. Co. BOARD OF EDUCATION			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Box 30 Broadneck Rd. 21401	
14. FATHER'S NAME FIRST MIDDLE LAST ERNEST E. RUSSELL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOTTIE M. SWAIN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 007-18-9943		17. INFORMANT ADDRESS DORIS E. RUSSELL (SAME AS 13)					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiac arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) **Diabetes Mellitus**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**minutes****year**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Stroke

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I, this hospital) attended the deceased from 19 77 , to 7/23 19 85 , that (I, we) last saw the deceased alive about 19 74 , and that in (my, our) opinion death occurred on the date and hour and from the causes stated above (I, we) (did) (did not) view the body after death.							
22b. SIGNATURE James Chaconas		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/23/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Chaconas		22e. ADDRESS 1521 Ritchie Hwy Arnold, Md					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JULY 25 1985		23c. NAME OF CEMETERY OR CREMATORY MARYLAND VETERAN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE CRANESVILLE ANNE ARUNDEL MD.	
24. FUNERAL DIRECTOR NAME BARRANCO FUNERAL HOME		501 RITCHIE HWY. SEVERNA PARK, MD		25a. DATE REC'D. BY REGISTRAR JUL 26 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by a case.

100-100000

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

MEMORANDUM FOR THE DIRECTOR
SUBJECT: [Illegible]

[Illegible body text]

Very truly yours,
[Illegible Signature]
Special Agent in Charge

203064

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8407	
1. DECEASED NAME (TYPE OR PRINT) JAMES A. RYAN										2a. DATE KNOWN OF DEATH 6 23 85	
3. SEX MALE 4. RACE CAU 5. DATE OF BIRTH DEC 20 29 55 6. AGE (IN YEARS) 29 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN										2b. DATE PRONOUNCED DEAD 6 23 85 2d. HOUR 1705	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL		
10. CITY OR TOWN OF DEATH ANNAPOLIS,			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GEN. HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT			12b. KIND OF BUSINESS OR INDUSTRY TRUCKING CO		
13a. STATE MD. 13b. COUNTY A.A. 13c. CITY OR TOWN ANNAPOLIS			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 830 MONROE ST #106					
14. FATHER'S NAME JAMES A. RYAN						15. MOTHER'S MAIDEN NAME KATHRYN MILUTINOV					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 090-20-5344			17. INFORMANT 12208 WESTMONT LA. JOEL K. RYAN BOWIE, MD. 20715					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest.											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ASCVD.											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Profound Anemia											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE William P. Jones, M.D.			M.D. Deputy MEDICAL EXAMINER					DATE SIGNED 6/23/85			
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.			ADDRESS 695 America Cr., Davidsonville, Md. 21035								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 7-2-85		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA FAIRFAX CO. VA.				
24. FUNERAL DIRECTOR NAME ROBERT E. EVANS ADDRESS 1212 WEST STREET ANNAPOLIS, MD. 21401						25a. DATE REC'D. BY REGISTRAR JUL 10 1985		25b. REGISTRAR'S SIGNATURE John Davidson			

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
500 5TH AVENUE NEW YORK 17, N.Y.

1919



June 10, 1919
To the Hon. J. P. Morgan
New York City
Dear Sir:
I have the honor to acknowledge
the receipt of your letter of
the 10th inst. regarding
the loan of the book
"The History of the
United States of America
from 1776 to 1876"
by John P. Morgan
to the New York Public
Library, Astor Lenox
Tilden Foundation.

The book is now in the
Library and will be
loaned to you as soon as
possible. It is a very
valuable book and I
trust you will find it
interesting and useful.
Very respectfully,
J. P. Morgan

William D. Howells
June 10, 1919

190147

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 85 18604				
1. DECEASED NAME (TYPE OR PRINT) ALBERT E. SANDERSON					2a. DATE OF DEATH MONTH DAY YEAR JULY 1 1985			2b. HOUR 4¹⁰ A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 30 1896		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH AA CO MD.			
10. CITY OR TOWN OF DEATH Edgewater		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) P.L.C.C.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Economist		12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't	
13a. STATE Md.		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Crownsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 346 South Riverside Dr 21032	
14. FATHER'S NAME FIRST MIDDLE LAST Albert Sanderson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amy Marie Hope				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW1		17. INFORMANT Benjamin & Albert Sanderson		ADDRESS 352 S. Riverside Dr Crownsville Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Prostate CA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> FEET WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>John P. Jones</i>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial			23b. DATE 7-3-85		23c. NAME OF CEMETERY OR CREMATORY Our Lady of the Fields		23d. LOCATION CITY OR TOWN COUNTY STATE Millersville A.A. Md.		
24. FUNERAL DIRECTOR NAME T.A. Hardesty ADDRESS Annapolis, Md. 21401					25a. DATE REC'D. BY REGISTRAR JUL 03 1985		25b. REGISTRAR'S SIGNATURE <i>William J. Anderson</i>		

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 REG. NO. 186 0DT5

1. DECEASED NAME [TYPE OR PRINT] FIRST MIDDLE LAST LAURA LAVINIA SAUNDERS			2a. DATE OF DEATH MONTH DAY YEAR JULY 25, 1985		2b. HOUR 935 PM
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Feb 22, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN WHICH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home
13a. STATE MD		13b. COUNTY AA	13c. CITY OR TOWN Pasadena	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 104 Mission St. 21122
14. FATHER'S NAME FIRST MIDDLE LAST Clarence Moore		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Otterbeine			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. XXXXXXXX 212/74/7306		17. INFORMANT ADDRESS James F. Saunders (son) Pasadena, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (b) Acute stenosis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 d 6 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Metabolic encephalopathy					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7-12 , 19 85 , to 7-25 , 19 85 , that (I) (we) lost saw the deceased alive on 7-25 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Long S. Hsu		DEGREE M.D.		22c. DATE SIGNED 7-26-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LONG S. HSU, M. D.		22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 104 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 29 July 1985		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Pk	
23d. LOCATION Glen Burnie		CITY OR TOWN AA		COUNTY MD	
24. FUNERAL DIRECTOR Singleton Funeral Home, Glen Burnie, MD		25a. DATE REC'D. BY REGISTRAR JUL 30 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

213002

DATE: 21 JUL 1962

TO: DIRECTOR, ARMY MEDICAL DEPARTMENT
FROM: [illegible]

SUBJECT: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

FILED



210145

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return the detached page to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, informed consent requires that the next of kin be notified.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 REG. NO. 18606

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lucille Schaper		MONTH DAY YEAR 7-8-85		1:30 PM	
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 9-16-04	6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.		
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GEN.		12a. USUAL OCCUPATION (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40) (41) (42) (43) (44) (45) (46) (47) (48) (49) (50) (51) (52) (53) (54) (55) (56) (57) (58) (59) (60) (61) (62) (63) (64) (65) (66) (67) (68) (69) (70) (71) (72) (73) (74) (75) (76) (77) (78) (79) (80) (81) (82) (83) (84) (85) (86) (87) (88) (89) (90) (91) (92) (93) (94) (95) (96) (97) (98) (99) (100) (101) (102) (103) (104) (105) (106) (107) (108) (109) (110) (111) (112) (113) (114) (115) (116) (117) (118) (119) (120) (121) (122) (123) (124) (125) (126) (127) (128) (129) (130) (131) (132) (133) (134) (135) (136) (137) (138) (139) (140) (141) (142) (143) (144) (145) (146) (147) (148) (149) (150) (151) (152) (153) (154) (155) (156) (157) (158) (159) (160) (161) (162) (163) (164) (165) (166) (167) (168) (169) (170) (171) (172) (173) (174) (175) (176) (177) (178) (179) (180) (181) (182) 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101-1

DEBIT NOTED



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
PENDING IN ITEM 1B. GIVE PAGES 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #6A. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
20M 4/82

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8607							
1. DECEASED NAME (TYPE OR PRINT) ELMER			FIRST JOHN			MIDDLE			LAST SCHIEK, JR.			2a. DATE KNOWN OF DEATH ESTIMATED 7 22 85			2b. HOUR ? M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 4 DAY 1 YEAR 30		6. AGE (IN YEARS) LAST BIRTHDAY 55 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD 7 23 85			2d. HOUR 0237 M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH A. A. MD.							
10. CITY OR TOWN OF DEATH Glen Burnie				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter				12b. KIND OF BUSINESS OR INDUSTRY Commercial					
13a. STATE Md.				13b. COUNTY P.G.				13c. CITY OR TOWN Laurel				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 3384 Wye Mills So.			
14. FATHER'S NAME FIRST Elmer MIDDLE John LAST Schiek, Sr.								15. MOTHER'S MAIDEN NAME FIRST Florence MIDDLE Gilmore LAST Gilmore											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. 328-24-2156				17. INFORMANT ADDRESS 13033 Old Stagecoach Rd. Laurel, Md. 20708											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Attack DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE J. S. Wheeler				M.D. Dr. MEDICAL EXAMINER 1716 Gumbottom Road Crownsville 21032				DATE SIGNED 7-23-85											
EXAMINER'S NAME (TYPE OR PRINT) James E. Wheeler, M.D.				ADDRESS Crownsville 21032															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7-26-85				23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.							
24. FUNERAL DIRECTOR NAME FLECK F.H. INC.				ADDRESS 7601 SANDY SPR. RD. LAUREL, MD. 20707				25a. DATE REC'D. BY REGISTRAR JUL 25 1985				25b. REGISTRAR'S SIGNATURE W. W. Anderson							

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 REG. NO. 18608

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERNARD W. SEARS			2a. DATE OF DEATH MONTH DAY YEAR 7 17 85			2b. HOUR 310 P	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 14 1901		6. AGE (IN YEARS LAST BIRTHDAY) 83	
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH ANNAPOHIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 843 BEST GATE RD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		12b. KIND OF BUSINESS OR INDUSTRY PRODUCE	
13a. STATE MD.		13b. COUNTY AA		13c. CITY OR TOWN ANNAPOHIS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS SEARS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA KING		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 214-18-2105	
17. INFORMANT ROGER W. SEARS		17. ADDRESS 110 Best Gate Road		17. CITY OR TOWN Annapolis, MD		17. ZIP CODE 21401	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia. DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia. DUE TO, OR AS A CONSEQUENCE OF (c) ① cerebrovascular accident.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4112 19 78 to 7 117 19 78 ②			
22a. I certify that (1) (this hospital) attended the deceased from 7/12 19 85 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (if we) (did) (did not) view the body after death.							
22b. SIGNATURE George C. Samaras				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/17/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George C. Samaras				22e. ADDRESS 205 Ridgely Ave Annapolis, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 20, 1985		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOHIS AA MD.	
24. FUNERAL DIRECTOR NAME Taylor Funeral				25a. DATE REC'D. BY REGISTRAR JUL 22 1985		25b. REGISTRAR'S SIGNATURE W. B. B. B. B.	

205018

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25MDHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	8	5	0	9
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anthony Worth Seitz										2a. DATE OF DEATH KNOWN OF ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7 15 1985		2b. HOUR M 3:55P M		
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 06-05-52		6. AGE (IN YEARS) LAST BIRTHDAY 33 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 15 1985		2d. HOUR M		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.		
11. CITY OR TOWN OF DEATH Annapolis				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rockwell Court (in auto)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waterman				12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland				13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1230 A Gemni Drive 21403				
14. FATHER'S NAME FIRST MIDDLE LAST Robert Myers Seitz, Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally Worth Seitz								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 210-40-0712		17. INFORMANT ADDRESS Robert M. Seitz Jr., 3143 Yale Ct. Woodbridge, VA 2219 8								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Carbon monoxide intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 7 15 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Inhaled exhaust fumes from auto								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street (in auto)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rockwell Court Annapolis A.A. MD.								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 7/16/85						
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn St. Balto. MD.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 07/17/85		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE P.G. CO Suittland MD				
24. FUNERAL DIRECTOR NAME ADDRESS Tom Helfenben Funeral Home, Chester, MD 21619						25a. DATE REC'D. BY REGISTRAR JUL 19 1985		25b. REGISTRAR'S SIGNATURE R. D. ...						

MEDICAL CERTIFICATION

81013



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 18610			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCES L. SELIG				July 4, 1985 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR November 20, 1935		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.	
10. CITY OR TOWN OF DEATH Pasadena		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1732 Poplar Ridge Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Block-manufact.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13e. STREET ADDRESS 1732 Poplar Ridge Rd. / 21122	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph F. Schroen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian E. Struewe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-30-1442		17. INFORMANT ADDRESS Charles J. Selig / 1732 Poplar Ridge Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF (b)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 6/1/85 to 7/4/85, that (1) (we) last saw the deceased alive on 6/15/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) see the body after death.							
22b. SIGNATURE E.W. Cole				DEGREE MD		22c. DATE SIGNED 7/5/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Enser Cole / Enser Cole				22e. ADDRESS 51 Franklin St. / Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 8, 1985		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, Anne Arundel, Md.	
24. FUNERAL DIRECTOR NAME Mountain & Tick Neck Rds. McCully Funeral Home / Pasadena, Md. 21122				25a. DATE REC'D. BY REGISTRAR JUL 10 1985		25b. REGISTRAR'S SIGNATURE	

211019

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 NO 1 8 6 1 1

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (Type in full) James T. Serafin			2a. DATE OF DEATH MONTH DAY YEAR 7 22 85		2b. HOUR 11:50 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 18 08		
6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
11. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Long Shoreman				
13. KIND OF BUSINESS OR INDUSTRY Shipping						
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY A.A.		13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME John		15. MOTHER'S MAIDEN NAME Mary		16. STREET ADDRESS / ZIP CODE 921 Church Street 21225		
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		18. SOCIAL SECURITY NO. 215-01-7933		19. INFORMANT Tena Serafin		
20. ADDRESS Same as 13c						
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Several years</u> Approximate interval between onset and death: <u>Several years</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Chronic Obstructive Pulmonary Disease</u>						
22a. DATE OF OPERATION		22b. CONDITION FOR WHICH OPERATION WAS PERFORMED		22c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
22d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
23d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		23e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		23f. LOCATION STREET CITY OR TOWN COUNTY STATE		
24. I certify that (I) (this hospital) attended the deceased from 19 <u>67</u> to <u>Present</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>7/1</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
25a. SIGNATURE Colvin Carter M.D.		25b. DEGREE M.D.		25c. DATE SIGNED 7/22/85		
25d. PHYSICIAN'S NAME (TYPE OR PRINT) Colvin Carter M.D.		25e. ADDRESS 4700 Pennington Ave Baltimore				
26a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		26b. DATE 7/25/85		26c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		
26d. LOCATION Balto		26e. COUNTY A.A.		26f. MD		
27. FUNERAL DIRECTOR George J. Gonce		27b. ADDRESS 4001 Ritchie Hwy Balto Md		27c. DATE REC'D. BY REGISTRAR JUL 26 1985		
27d. REGISTRAR'S SIGNATURE J. Davidson-Randall						

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 18612

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles William Sharps			2a. DATE OF DEATH MONTH DAY YEAR July 19 1985		2b. HOUR 12³⁰ PM			
3. SEX Male		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR Oct 14 1919		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. MD.		
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1022 Monroe St			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Naval Acdy	
13a. STATE Md		13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Robert Washington Sharps		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Elizabeth Turner		13e. STREET ADDRESS 1022 Monroe St 21403				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW. 11		17. INFORMANT ADDRESS Agnes Sharps 1022 Monroe St Anna, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) BRAIN METASTASES Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) LUNG CANCER							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: RENAL FAILURE								
19a. DATE OF OPERATION SEPTEMBER 1984		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Lung Cancer		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from MARCH 17 1980 to JULY 19 1985 , that (I) (we) last saw the deceased alive on July 19 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Donald C. Roane		DEGREE MD		22c. DATE SIGNED 7/19/85		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald C. Roane MD		
22e. ADDRESS 1616 Forest Drive Annapolis, Md		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						
23b. DATE 7-25-1985		23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Md				
24. FUNERAL DIRECTOR NAME ADDRESS C.E. Hicks, 111 1922 Forest Drive				25a. DATE REC'D. BY REGISTRAR JUL 22 1985				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

BP

060-783

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204014

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 85 1 8 6 1 3

1- FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Jimmy

Frank

Shephard, III

2a. DATE KNOWN
OF DEATH ESTI-
MATED

JULY 6 19 85

2b. HOUR

8:06

3 SEX
MALE4 RACE
BLACK5. DATE OF BIRTH
APRIL 27 856. AGE (IN YEARS
LAST BIRTHDAY)
YRS. 2IF UNDER 1 YR.
MONTHS 2IF UNDER 24 HRS.
DAYS 2

HOURS 2

MIN 2

2c. DATE
PRONOUNCED
DEAD

JULY 6 19 85

A M

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
WASHINGTON D.C.7b. CITIZEN OF WHAT COUNTRY?
U.S.A.8 MARRIED ☐ NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐9 BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County, MD.10. CITY OR TOWN OF DEATH
Ft. Meade11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Kimbrough Army Hospital12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
NONE12b. KIND OF BUSINESS
OR INDUSTRY
N/A

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
MD13b. COUNTY
A.A.13c. CITY OR TOWN
FT. MEADE13d. INSIDE CITY LIMITS?
YES ☐ NO ☒13e. STREET ADDRESS
7338 C KELLY LOOP 2075514. FATHER'S NAME
FIRST JIMMY

MIDDLE FRANK

LAST SHEPHARD, JR.

15 MOTHER'S MAIDEN NAME
FIRST ELIZABETH

MIDDLE A.

LAST WARD

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO(IF YES, GIVE WAR OR DATES)
N/A16b. SOCIAL SECURITY NO.
NONE17. INFORMANT (Father) ADDRESS
Jimmy F. Shephard, Jr. Same as #1318 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Sudden Infant Death Syndrome

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opiniondeath resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

[Signature]

M.D. Assistant MEDICAL EXAMINER

DATE SIGNED 7/7/85

EXAMINER'S NAME
(TYPE OR PRINT)

Gregory R. Kauffman, M.D.

ADDRESS 111 Penn St.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL23b. DATE
JULY 13, 198523c. NAME OF CEMETERY OR CREMATORY
GLEN HAVEN MEM. PARK23d. LOCATION
CITY OR TOWN GLEN BURNIE

COUNTY A.A.

STATE MD.

24 FUNERAL DIRECTOR
NAME

SINGLETON FUNERAL HOME GLEN BURNIE, MD. 21061

25a. DATE REC'D. BY REGISTRAR

JUL 16 1985

25b. REGISTRAR'S SIGNATURE

[Signature]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT RECEIPT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
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DHMH - 17
(VR A15 ME (5))

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LEGAL INDEX

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 REG. NO. 186 EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MABEL MADDRIX SHETTL			2a. DATE OF DEATH MONTH DAY YEAR JULY 14, 1985		2b. HOUR 1104 AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 12, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Severna Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Maddrix				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				13e. STREET ADDRESS / ZIP CODE 21146 47 West Earleigh Heights Road	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (Son) Mr. Thomas H. Michaels		ADDRESS 49 W. Earleigh Hgts. Rd. Severna Park, Md. 21146			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from NA , 19____, to____, 19____, that (I) (we) last saw the deceased alive on____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
22b. SIGNATURE Donald Hislop, M.D.						DEGREE M.D.		22c. DATE SIGNED 7-15-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD HISLOP, M. D.						22e. ADDRESS 33 ROBINSON ROAD SEVERNA PARK, MARYLAND 21146			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 17, 1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Park, A.A. Md.		
24. FUNERAL DIRECTOR NAME R. M. Hopkins						ADDRESS Singleton Funeral Home, Glen Burnie, Maryland		25a. DATE REC'D. BY REGISTRAR JUL 16 1985	
25b. REGISTRAR'S SIGNATURE John W. Davidson									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove completion papers, pages 1 and 2, should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DATE: JUL 1 1962 TIME: 10:00 AM

WEST WINDING ROAD

WEST WINDING ROAD

WEST WINDING ROAD
SOUTH BAY, MARYLAND 21150

WEST WINDING ROAD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			EDT
JAMES WILLIAM SHIPLEY			JULY 11, 1985			539 PM			M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		White		Oct. 30 1917		67 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
W.. Virginia		U.S.A.				ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT HOME, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
GLEN BURNIE		NORTH ARUNDEL HOSPITAL				Tool Repairer		Md. Drydock	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS / ZIP CODE		13e. INSIDE CITY LIMITS?	
Md.		Anne Arundel		Glen Burnie		7822 South Hampton Dr. Glen Burnie		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST Russell Shipley			FIRST MIDDLE LAST Maudie Miskie						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
No			220-10-0830			Betty Shipley same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>AS AD.</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
(b) <u>Acute pulmonary edema</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>Acute ventricular failure.</u>									
(c) <u>Acute respiratory arrest.</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Generalized arteriosclerosis</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
N/A						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
			HOUR A.M. MONTH DAY YEAR P.M. 19			N/A			
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			[AT HOME STREET, FACTORY, OFFICE, FARM, ETC.]			CITY OR TOWN COUNTY STATE			
						N/A			
22. I certify that (I) (this hospital) attended the deceased from <u>June 27</u> , 19 <u>85</u> , to <u>July 11</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>July 11</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
23. SIGNATURE						DEGREE		23c. DATE SIGNED	
<u>Benjamin de Guzman, M.D.</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		July 11, 1985	
24. PHYSICIAN'S NAME (TYPE OR PRINT)						25. ADDRESS			
BENJAMIN A. DE GUZMAN, M. D.						525 HOSPITAL DRIVE, SUITE 108 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial			7-15-85		Glen Haven Mem. Park		Glen Burnie Anne Arundel Md.		
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
McCuilly F.H. 3204 Mountian Rd. Pasadena, Md. 21122						JUL 17 1985			

BP

100-1000

DATE: JULY 21, 1963 TIME: 10:00 AM

TO: MR. J. E. HARRIS

FROM: MR. J. E. HARRIS

SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

205066

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/B2

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8616

1. DECEASED NAME (TYPE OR PRINT) GEORGIANNA ANN SHORTER			20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 7 DAY 13 YEAR 1985 2b. HOUR 1:00 PM	
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH July DAY 24 YEAR 1920	6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	7. IF UNDER 1 YR. MONTHS DAYS
8. IF UNDER 24 HRS. HOURS MIN. 	2c. DATE PRONOUNCED DEAD MONTH 7 DAY 13 YEAR 1985 2d. HOUR 1:31 PM		9. BALTIMORE CITY OR COUNTY OF DEATH A. A.	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		11. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
12. CITY OR TOWN OF DEATH Glen Burnie		13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) D.O.A North Arundel		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife
15. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE MD 12b. CITY OR TOWN A.A. 12c. CITY OR TOWN Gambells		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 2550 Carver Rd 21054		14. KIND OF BUSINESS OR INDUSTRY
14. FATHER'S NAME FIRST BENJAMIN MIDDLE LAST Parker		15. MOTHER'S MAIDEN NAME FIRST Josephine MIDDLE LAST Parker		16. ADDRESS Gambells
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		17b. SOCIAL SECURITY NO. 216-68-7791		17c. INFORMANT Augustine Shorter ADDRESS 2550 Carver Rd
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) 				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE James E. Wheeler		TITLE (SPECIFY) Dep. MEDICAL EXAMINER		DATE SIGNED 7-13-85
EXAMINER'S NAME (TYPE OR PRINT) James E. Wheeler, M.D.		ADDRESS Crownsville 21032		
23a. BURIAL, CREMATION, REMOVAL (RECY) BURIAL		23b. DATE 7-18-1985		23c. NAME OF CEMETERY OR CREMATORY Wilson
23d. LOCATION CITY OR TOWN Crofton COUNTY A.A. STATE MD		24. FUNERAL DIRECTOR NAME C. E. Hicks ADDRESS 1922 Forest Drive		
25a. DATE REC'D. BY REGISTRAR JUL 19 1985		25b. REGISTRAR'S SIGNATURE [Signature]		

220705

159135

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8518617

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE BESSIE LAST SMITH			2a. DATE OF DEATH MONTH DAY YEAR 7 2 85		2b. HOUR 2 A _M						
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6-4-1917		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY BRUSH FACTORY			
13a. STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Arnold		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 937 LAKE DRIVE 21012		
14. FATHER'S NAME FIRST MIDDLE LAST ANDREW L. Duerling			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE PEISFFER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 202203		17. INFORMANT ADDRESS FAMILY RECORDS						
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF: (b) Renal Failure DUE TO, OR AS A CONSEQUENCE OF: (c) Atherosclerotic Disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 3 weeks —	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Abdominal Aortic Aneurysm, acute											
19a. DATE OF OPERATION 5-30-85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Expanding Aneurysm			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) the hospital attended the deceased from <u>5-28</u> 19 <u>85</u> to <u>7-2</u> 19 <u>85</u> that (I) have last saw the deceased alive on <u>7-1</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) view <input checked="" type="checkbox"/> (did) <input type="checkbox"/> view the body after death.											
22b. SIGNATURE K. P. Holschuh			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7-2-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. HOLSCHUH			22e. ADDRESS 16 MURRAY AVE. ANNAPOLIS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE JULY 5, 1985		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE PARKVILLE BALTO. MARYLAND				
24. FUNERAL DIRECTOR NAME EVANS CHARLOTTE MEMORIES			ADDRESS 8800 HARFORD ROAD			25a. DATE REG'D. BY REGISTRAR JUL 05 1985			25b. REGISTRAR'S SIGNATURE		

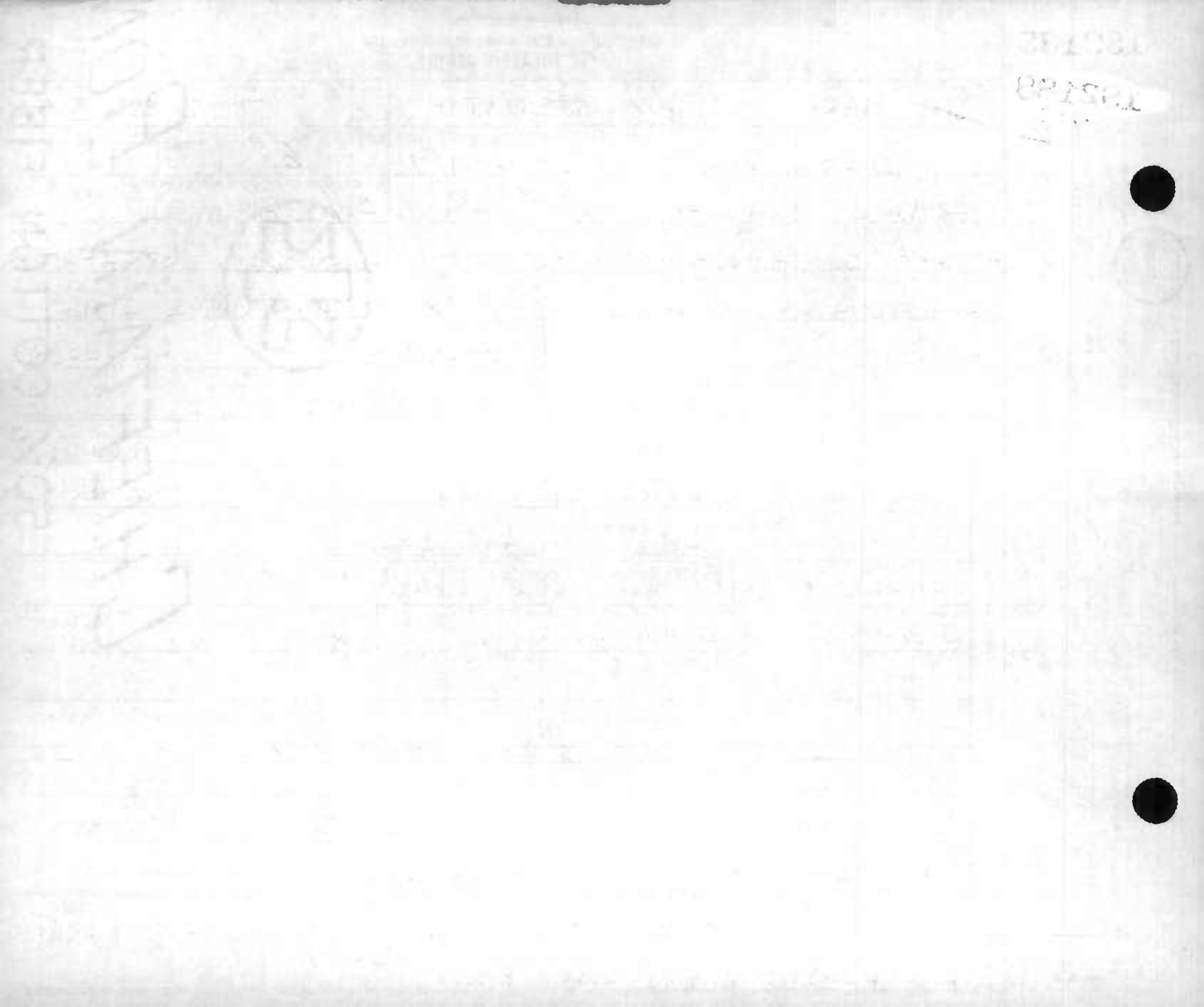
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP



193031

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO. 8618

DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Paul		Alonzo		Smith				7/		6/		19		85		M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 13 57		6. AGE (IN YEARS) LAST BIRTHDAY 27 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		7/ 6/ 19 85		1:15 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.											
10. CITY OR TOWN OF DEATH Severn		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Chase Creek		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bethlehem Steel Foreman		12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21222 2011 Barry Rd.									
14. FATHER'S NAME FIRST MIDDLE LAST William T. Smith		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie Brown															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 66 2409		17. INFORMANT ADDRESS Mrs. Sharon Smith 2011 Barry Rd.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9109 IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>subject drowned</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>subject drowned</u>																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 7/ 6/ 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject drowned													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) creek		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Pines on Severn, Chase Creek, Severn, Md.													
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 7/7/85					
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.		ADDRESS 111 Penn St.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/12/85		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills											
24. FUNERAL DIRECTOR NAME James A. Morton & Sons		ADDRESS 1701 Laurens		25a. DATE REC'D. BY REGISTRAR JUL 08 1985		25b. REGISTRAR'S SIGNATURE 											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETURN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201.

07/B4
25M

BP
DHMH - 17
(VR A15 ME (5))

6



2022 COLLOID FEB

22 MAR 1903

214038

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 18619

1. DECEASED NAME (TYPE OR PRINT) Ruth B. Sobl			2a. DATE OF DEATH MONTH 7 DAY 26 YEAR 85 2b. HOUR 11 P. M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH Jan. DAY 1 YEAR 1896	6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co., MD	
10. CITY OR TOWN OF DEATH Edgewater	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant Living Convalescent Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE MD	13b. COUNTY A.A.	13c. CITY OR TOWN Arnold	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 1441 Grandview Road
14. FATHER'S NAME FIRST Harry MIDDLE N. LAST Sponsler		15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE L. LAST Nicholson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO.		16b. SOCIAL SECURITY NO. 213-76-1480		17. INFORMANT Harold K. Sobl.
16c. ADDRESS Same as #13				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio - Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerotic Cardio-Vascular yrs DUE TO, OR AS A CONSEQUENCE OF (c) 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from Feb 19 73 to July 19 85 , that (1) (we) last saw the deceased alive on 6/7 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Barry R. Nathanson		DEGREE DR. RICHARD FEECER ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/29/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY R. NATHANSON MD		22e. ADDRESS 51 FRANKLIN ST. ANNAP, MD 21401			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE July 30, 1985	23c. NAME OF CEMETERY OR CREMATORY Loudon Park	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City MD
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD		25a. DATE REC'D. BY REGISTRAR JUL 31 1985	25b. REGISTRAR'S SIGNATURE John Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP
DHMH-16 50M/1/B1
(VRA 15, 4)

2

116

Washington, D.C. 20540
Mr. J. Edgar Hoover
Director, FBI

Dear Mr. Hoover:

I am writing to you regarding the matter of the

recently received information concerning the

activities of the [redacted] group.

I have been advised that the [redacted] group

is active in the [redacted] area.

I am sure that you will find this information

of interest and will take appropriate action.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be stored for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		851862DTJ REG. NO.	
2a DECEASED NAME (TYPE OR PRINT)		3 SEX		4 DATE OF DEATH	
IRVING JACKSON SPARROW		MALE		JULY 3, 1985	
5 BIRTHPLACE (STATE OR FOREIGN COUNTRY)		6 DATE OF BIRTH		7b HOUR	
VIRGINIA		JAN. 1, 1893		1201 AM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
VIRGINIA				ANNE ARUNDEL COUNTY MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a USUAL OCCUPATION	
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		POLICE	
13a STATE		13b COUNTY		12b KIND OF BUSINESS OR INDUSTRY	
MD		A.A.		BALTIMORE CITY	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES?	
JOSEPH SPARROW		SARAH UNKNOWN		NO NONE	
17 INFORMANT (DAUGHTER IN LAW)		18. CAUSE OF DEATH		19a DATE OF OPERATION	
MRS. LOVERA E. SPARROW		RESPIRATORY FAILURE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
SAME AS #13		OPIRATORY PNEUMONIA		20a AUTOPSY?	
		C#5		YES <input type="checkbox"/> NO <input type="checkbox"/>	
				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
				21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
				21b. TIME OF INJURY	
				HOUR A.M. MONTH DAY YEAR	
				P.M. 19	
				21c. HOW INJURY OCCURRED	
				(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
				21d. INJURY OCCURRED	
				21e. PLACE OF INJURY	
				(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	
				21f. LOCATION	
				STREET CITY OR TOWN COUNTY STATE	
				22a. I certify that (I) (this hospital) attended the deceased from 6-22-1985 to 7-3-1985, that (I) (we) lost	
				saw the deceased alive on 7-3-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated	
				22b. SIGNATURE	
				DEGREE	
				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
				22c. DATE SIGNED	
				7-3-85	
				22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
				SACIT EREN, M.D.	
				22e. ADDRESS	
				518 SOUTH CAMP MEADE ROAD	
				LINTHICUM, MARYLAND 21090	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		JULY 5, 1985		BALTIMORE CEMETERY	
23d. LOCATION		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION	
BALTIMORE CITY		BALTIMORE CITY		BALTIMORE CITY	
24 FUNERAL DIRECTOR		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE	
NAME		DATE		SIGNATURE	
SINGLETON FUNERAL HOME GLEN BURNIE, MD.21061		JULY 05 1985		[Signature]	

4-29-73

UNITED STATES DEPARTMENT OF THE ARMY
HEADQUARTERS, 101st AIRBORNE DIVISION
FORT MONMOUTH, NEW JERSEY 08041
ATTENTION: G-3
DATE: 4-29-73
TO: 101st AIRBORNE DIVISION
FROM: 101st AIRBORNE DIVISION
SUBJECT: [illegible]

2



MINUTE

20% C-119

101st AIRBORNE DIVISION
FORT MONMOUTH, NEW JERSEY 08041

214097

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 REG. NO. 1 8 6 2 1

1. DECEASED NAME (TYPE OR PRINT) Dorothy K. SPIERS			2a. DATE OF DEATH MONTH DAY YEAR 7-26-85		2b. HOUR 8:20 AM
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR JANUARY 24, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WISCONSIN	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.	
10. CITY OR TOWN OF DEATH SEVERNA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 78 RIVERSIDE DR.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN SEVERNA PARK	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM C. KIMBALL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE HEBERLIEN		13e. STREET ADDRESS / ZIP CODE 78 RIVERSIDE DR. 21146	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 067-38-6020	17. INFORMANT ADDRESS ARDATH CADE (SAME AS ABOVE - 13)			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

metastatic mixed mesodermal sarcoma

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

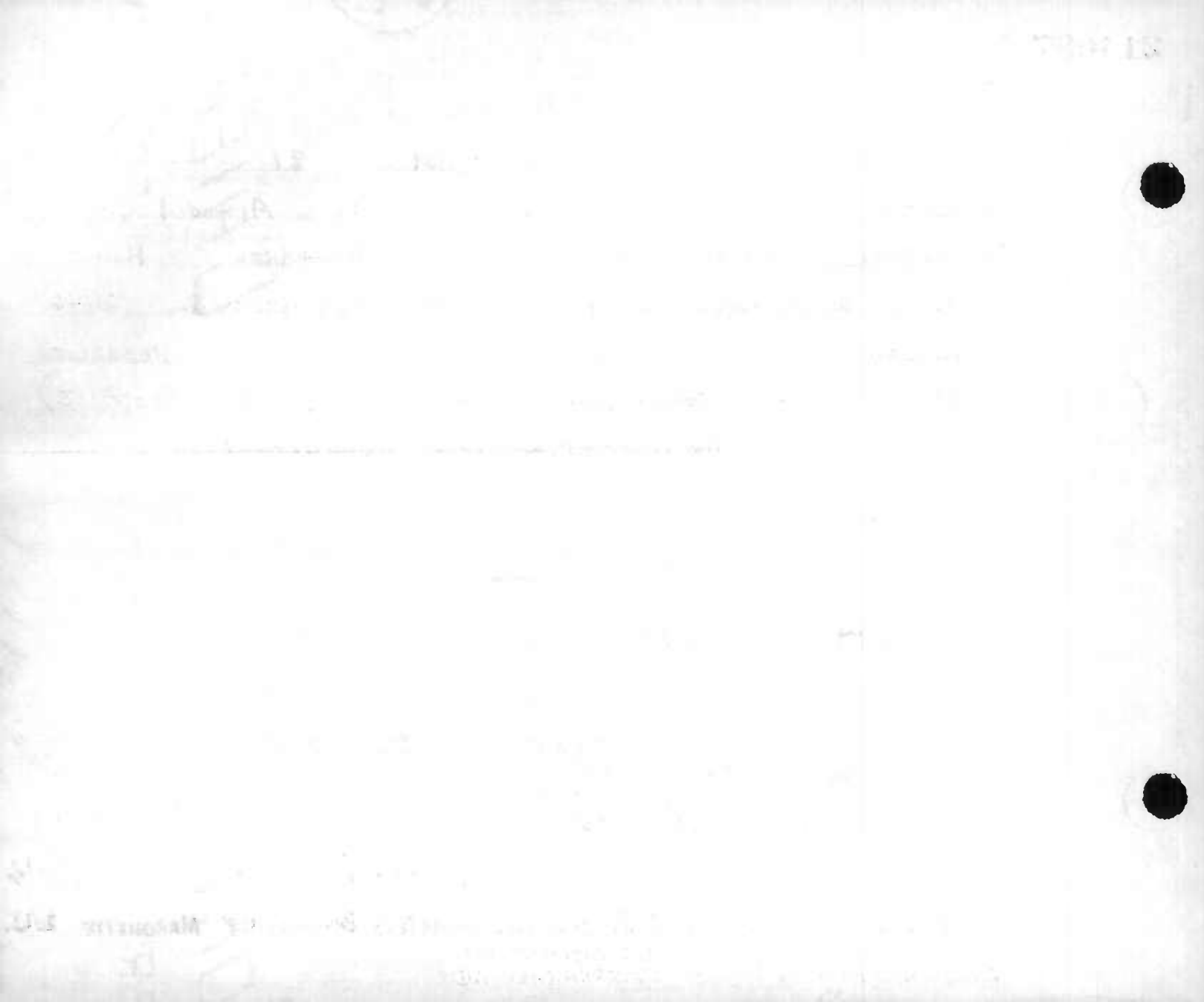
19a. DATE OF OPERATION N/A	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7-22 , 19 85 , to 7-26 , 19 85 , that (I) (we) lost saw the deceased alive on 7-22 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Donald H. Kirl		22c. DATE SIGNED 7-26-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald H. Kirl, M.D.		22e. ADDRESS Robinson Rd + Owens Way Severna Park, MD. 21146	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE JULY 29, 1985	23c. NAME OF CEMETERY OR CREMATORY BRIGGSVILLE CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE BRIGGSVILLE MARQUETTE WIS.
24. FUNERAL DIRECTOR NAME BARBARCO FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR JUL 30 1985	25b. REGISTRAR'S SIGNATURE John Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonized parts. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



213099

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 5 1 8 6 2 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SARAH <i>Melissa</i> <i>Stephens</i>			2a. DATE OF DEATH MONTH DAY YEAR 7 28 85			2b. HOUR 5 45 AM				
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 8 10 97		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Front Royal Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD				
10. CITY OR TOWN OF DEATH <i>Edgewater</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>P.A.C.C.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dept. of Fish & Wildlife sec.		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY A.A. Co.		13c. CITY OR TOWN Mayo		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 107 Elliott Pl. <i>21104</i>	
14. FATHER'S NAME FIRST MIDDLE LAST John L. Melton			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Carr							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT A William C. Stephens Mayo. Md.		ADDRESS 107 Elliott Pl.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral anoxia.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiac failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerosis.</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate.</i> <i>Immediate.</i> <i>Yrs.</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Chronic Brain Syndrome</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>William H Choate M.D.</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>28 Jul 85.</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/31/85		23c. NAME OF CEMETERY OR CREMATORY Mayo U.M. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Mayo A.A. Md.			
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home					12 Ridgely Ave. ADDRESS Ann. Md. 21401		25a. DATE REC'D. BY REGISTRAR <i>JUL 30 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Johanna Davidson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
HYACINTH SUMNER			7 30 85			9:00 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. YRS	
F		NEGRO		8 7 1902		82			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Georgia		USA				Anne Arundel Cty MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF PLACED IN INSTITUTION GIVE INSTITUTION ADDRESS)				12a. USUAL OCCUPATION (IF PLACED IN INSTITUTION GIVE INSTITUTION ADDRESS)		12b. KIND OF BUSINESS OR INDUSTRY	
Harwood		Brashears Nursing Home				Nursing ASST			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		14. STREET ADDRESS / ZIP CODE	
Maryland		AA		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		41 Dean Street 21401	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
James Lee		Janie Lee							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				Benjamin Dunmore 7806 Glenarden Pkwy Lanham, Md 20706					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Pulmonary Embolus likely									
DUE TO, OR AS A CONSEQUENCE OF (b) Fractured hip, Rt									
DUE TO, OR AS A CONSEQUENCE OF (c) fall at home									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
8842 Immediate 7-16-85									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:									
Diabetes mellitus - Atrial Fibrillation - AK amputee Rt.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY?		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
7/19/85		Fx hip		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY		20c. HOW INJURY OCCURRED		20d. ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2			
		4:30 P.M. 7 16 1985		fell off bed side commode.					
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. LOCATION		21d. CITY OR TOWN			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Home		Street		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-29-85 to 7-31-85, that (I) (we) last saw the deceased alive on 7-28-85, and that in (my) (our) opinion death occurred on the date stated and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
Peter F. Verkouw		MEDICAL EXAMINER		7/31/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Peter F. Verkouw		1833 Forest Dr. Annapolis, Md 21401							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		8/3/85		Hillcrest Cemetery		Annapolis, Md COUNTY AA Cty STATE			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
William Reese & Sons Mrtys Annapolis, Md				AUG 8 1985					

1

Harwood

Harwood

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207008

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 1862 EDT
REG. NO.

FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
		RAYMOND NEWTON TALLMAN		JULY		20,		1985		1030		PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		Jan. 29, 1913		72		YRS		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Ohio		U.S.A.				ANNE ARUNDEL COUNTY						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		Superintendent		Ship Yard							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		AnneArundel		Arnold		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		818 Mill Creek Road		21012			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
James		Tallman		Fern		Campbell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
Yes		W.W. II		217.16.0014		Lillian M. Tallman		Wife		Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Congestive Heart Failure		Chronic renal Failure											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 5-31, 19 85, to 7-20, 19 85, that (I) (we) lost saw the deceased alive on 7-20, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
SANG C. DOH, M. D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		7-22-85									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
		95 AQUAHART ROAD GLEN BURNIE, MARYLAND 21061											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		July 23, 1985		Holly Hill Mem Gard.		Middleriver Balto Md.							
24. FUNERAL DIRECTOR NAME		24b. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Singleton Funeral Home, Glen Burnie, Maryland		JUL 23 1985		une Davidson-Randall									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with your files after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

200000



Handwritten notes and markings on the left margin, including a vertical line of text and several horizontal strokes.

Main body of the document containing faint, mostly illegible text and markings, possibly representing a ledger or record.

Bottom section of the document with additional faint text and markings, including a horizontal line and some illegible characters.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO. 1 8 6 2 5

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LILLIAN M. THOMAS			2a. DATE OF DEATH MONTH DAY YEAR 7-16-85		2b. HOUR 6 ¹⁹ P.M.	
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 10 26 1916		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Annapolis MD.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AA-94			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE 13a. STATE MD		13b. COUNTY AA CO	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST HOWARD SISCOE		15. MOTHER'S MAIDEN NAME MIDDLE LAST BESSIE MURRY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT Annapolis, Md. 21403 EARL SISCOE 202 Garden Gate Lane		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Actual pneumonia

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/16/85, 1985, to 7/16, 1985, that (I) (we) lost saw the deceased alive on June 19 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE ERROL-A-Phillips MD				22c. DATE SIGNED 7/17/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
ERROL-A-Phillips MD				1835 Forest Drive Annapolis, MD 21401	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 7-20-1985	23c. NAME OF CEMETERY OR CREMATORY PINELAWN MEM. PARK	23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland
24. FUNERAL DIRECTOR WILLIAM REESE & SONS MORTUARY, P.A. Annapolis, Md. 21401			25a. DATE REC'D. BY REGISTRAR JUL 19 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 4 and 5 should be filled with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

214020

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it must be taken to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
LAVIN		H		TISDALE				7 21 85		12 NOON M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.	
MALE		WHITE		10 08 06		78 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
SOUTH CAROLINA		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUALLY STATIONARY (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
ANNAPOLIS		ANNE ARUNDEL GENERAL HOSPITAL						STATIONARY		ENGINEER BALTIMORE FIRE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		DEPT.	
MARYLAND		ANNE ARUNDEL		ANNAPOLIS		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1607 BAY RIDGE AVE. 21403			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
ROBERT HENRY TISDALE				NANNIE A. RODGERS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
YES				1926-1927		VIOLET L. EATON SAME AS 13E					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) RESPIRATORY ARREST										1 MINUTE	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										2 WKS.	
DUE TO, OR AS A CONSEQUENCE OF											
(c) CHRONIC OBSTRUCTIVE PULMONARY DISEASE										10 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 9/5, 19 84, to 7/21, 19 85, that (2) (we) lost the deceased alive on 7/20, 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we (2) did not view the body after death.											
22b. SIGNATURE								DEGREE		22c. DATE SIGNED	
Robert Scott Eden, M.D.								ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		7/21/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
ROBERT SCOTT EDEN						703 GIDDINGS AVE. ANNAPOLIS, MD. 21401					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL				7-24-85		MORELAND MEMORIAL PARK		BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
ROBERT E. EVANS ANNAPOLIS, MARYLAND								JUL 31 1985		Davidson	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSMIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8627	
1. DECEASED NAME (TYPE OR PRINT) Isabel Bamberger TOLSON										7b. DATE KNOWN OF DEATH MATED <input type="checkbox"/> 7/7/85	
3. SEX F	4. RACE CAU	5. DATE OF BIRTH MONTH 8 DAY 6 YEAR 03	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN. 	7c. DATE PRONOUNCED DEAD MONTH 7 DAY 7 YEAR 85		7d. HOUR 0421			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Md.		13b. COUNTY Queen Anne's		13c. CITY OR TOWN Stevensville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21666 105 N. LAKE Dr.			
14. FATHER'S NAME FIRST Harry MIDDLE --- LAST Bamberger				15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Elizabeth LAST Wyatt							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-74-2887		17. INFORMANT Son ADDRESS 165H Sparks Road Franklin H. Tolson, Ridgely, Md. 21660							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY Arrest Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: AS.C.V.D. (b) AS.C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE William P. Jones, M.D.				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 7/7/85			
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.				ADDRESS 695 America Crt., Davidsonville, Md. 21035							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 10, 1985		23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery				23d. LOCATION CITY OR TOWN Centreville COUNTY Q.A.Co. STATE Md.			
24. FUNERAL DIRECTOR NAME James H. Barton, Jr., Centreville, Md. 21617				25a. DATE REC'D. BY REGISTRAR JUL 15 1985				25b. REGISTRAR'S SIGNATURE John Davidson			

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James H. Green, Jr. 100-10000

Green, James H. 100-10000

James H. Green, Jr. 100-10000
James H. Green, Jr. 100-10000

James H. Green, Jr. 100-10000

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James H. Green, Jr. 100-10000
James H. Green, Jr. 100-10000

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FOR
STATE
REGISTRAR Mary Wilhelmina Trott

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 8 6 2 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILHELMINA TROTT			2a. DATE OF DEATH MONTH DAY YEAR 7 3 85		2b. HOUR 3:05 AM		
3. SEX F Female		4. RACE W White		5. DATE OF BIRTH MONTH DAY YEAR 8 29 20		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE Arundel MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE Arundel Gen.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Cantwell-Cleary	
13a. STATE Maryland		13b. CITY OR TOWN Pr. Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Box 36, Dares Beach Rd. 20678	
14. FATHER'S NAME FIRST MIDDLE LAST George L. Freeland				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Frances Finn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Clinton Trott SAME AS # 13 A - E			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Goodpasture's syndrome DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Acute renal failure, renal vasculitis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from June , 19 85 , to 7-3 , 19 85 , that (we) lost saw the deceased alive on 7-2 , 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.							
22b. SIGNATURE G Mitchell				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-3-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G Mitchell				22e. ADDRESS 205 Ridge St Annapolis 21401			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-06-1985		23c. NAME OF CEMETERY OR CREMATORY St. Pauls (annex)		23d. LOCATION CITY OR TOWN COUNTY STATE Pr. Frederick, Calvert, Md..	
24. FUNERAL DIRECTOR NAME Donald V. Borgwardt				25. DATE RECEIVED BY REGISTRAR JUL 10 1985			
ADDRESS Rt. #264, Box 34B, Port Republic, Maryland 20676				26. REGISTRAR'S SIGNATURE Jane Davidson-Robert			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO. 8 5 1 8 6 2 9

1. DECEASED NAME (TYPE OR PRINT) Phyllis ANN VAN VRANKEN			2a. DATE OF DEATH MONTH DAY YEAR JULY 31, 1985		2b. HOUR 5 30 P.M.
3. SEX FEMALE	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR FEB. 12, 1932	6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) KANSAS	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL Co.		
10. CITY OR TOWN OF DEATH SEVERNA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 16 CINDY COURT		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN SEVERNA PK	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 16 CINDY COURT - 21146	
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD COYLE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN FLINT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-30-9387		17. INFORMANT ADDRESS Thomas C. VAN VRANKEN 16 CINDY CT. SEV. PK MD	

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CAT CELL CARCINOMA OF LUNG

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

ONE YEAR

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>July 29</u> , 19 <u>89</u> , to <u>July 31</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>June 29</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Frank R. Jackson</u>	DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>7-31-85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>FRANK R. JACKSON MD</u>		22e. ADDRESS <u>3 VILLAGE GREEN, CROFTON, MD</u>	

23a. BURIAL, CREMATION, REMOVAL (TYPE)	23b. DATE 8-1-85	23c. NAME OF CEMETERY OR CREMATORY WESTVIEW CEM.	23d. LOCATION CITY OR TOWN COUNTY STATE WESTVIEW, BALT. MD.
24. FUNERAL DIRECTOR NAME BARRANCO Fw. Ym. 501 RITCHIE HWY SEVERNA PK, MD 21146		25a. DATE REC'D. BY REGISTRAR 8-6-85	25b. REGISTRAR'S SIGNATURE <u>John R. Randle</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove and destroy this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

BP

PHOTOGRAPHED BY: [illegible]
DATE: [illegible]
U.S.A. [illegible]
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		85 G. NO. 18630							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charles A. Venner III				2a. DATE OF DEATH MONTH DAY YEAR 7/23/85		2b. HOUR 10:35 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 06 24 25		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Quality Control		12b. KIND OF BUSINESS OR INDUSTRY Food	
13a. STATE Maryland				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles A. Venner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May Weber					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 155 18 75 74		17. INFORMANT Mary C. Venner		ADDRESS Same as #13			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ischemic Cardiomyopathy. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/23/85 to 7/23/85, that (I) (we) lost sight of the deceased alive on 7/23/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE Richard Peeler				DEGREE ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/23/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Peeler				22e. ADDRESS 57 Franklin St. Annapolis MD 21401					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 7/25/85		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND P.GEO. MD.			
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel				ADDRESS Annapolis MD		25a. DATE REC'D. BY REGISTRAR JUL 31 1985		25b. REGISTRAR'S SIGNATURE	

STAMP



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon patient page and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) Catherine Anna Vodak		20. DATE OF DEATH MONTH DAY YEAR July 12 1985		2b. HOUR 5:12 M					
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Feb. 5 1921	6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balt. Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.						
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Purchasing agent		12b. KIND OF BUSINESS OR INDUSTRY DNR				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.		13b. COUNTY A.A. Co.	13c. CITY OR TOWN Riva	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2 Butternut Rd. 21140				
14. FATHER'S NAME FIRST MIDDLE LAST Henry Wirth		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-12-3960		17. INFORMANT Kathryn Norfolk ADDRESS 2618 Bay City Stevensville, Md. 21666					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) metastatic carcinoma of colon DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Bronchospasm									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7-8 1985 to 7-12 1985, that (I) (we) last saw the deceased alive on 7-12 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE G. Mitchell MP		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-12-85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G Mitchell MP		22e. ADDRESS 205 Ridgely Ave Annapolis							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/16/85		23c. NAME OF CEMETERY OR CREMATORY Lakemont Cemetery					
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home		24. ADDRESS 12 Ridgely Ave. Annapolis, Md.		25a. DATE REC'D. BY REGISTRAR JUL 18 1985					
25b. REGISTRAR'S SIGNATURE William H. Henderson									

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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FOR
STATE
REGISTRAR

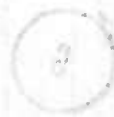
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 RES. NO. 1 8 6 3 EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM F. WAMPLER, SR.			2a. DATE OF DEATH MONTH DAY YEAR JULY 18, 1985		2b. HOUR A. 9:23 M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 8, 1905		
6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.						
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory Work		
12b. KIND OF BUSINESS OR INDUSTRY Labor -Maint.						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1223 Hillside Rd/pasadena, 21122				
14. FATHER'S NAME FIRST MIDDLE LAST Joseph - Wampler			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane - Larkin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-01-6473		17. INFORMANT ADDRESS 704 East MacPhail Rd. William Wampler, Jr./Belair, Md. 21014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immed DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease immed DUE TO, OR AS A CONSEQUENCE OF (c) Anemic upper gastro intestinal bleed days						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: COPD						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from July 15, 1985 to July 19, 1985 that (I) (we) last saw the deceased alive on July 18, 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE IRA E. KAPLAN, M.D.		DEGREE		22c. DATE SIGNED 7/18/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRA E. KAPLAN, M.D.		22e. ADDRESS 7845 OAKWOOD ROAD, #200 GLEN BURNIE, MARYLAND 21061				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 20, 85		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, Anne Arundel, Md.						
24. FUNERAL DIRECTOR NAME McCully Funeral Home/		ADDRESS Mountain & Tick Neck Rds. Pasadena, Md. 21122		25a. DATE REC'D. BY REGISTRAR JUL 22 1985		
25b. REGISTRAR'S SIGNATURE Johia Davidson-Randell						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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LIBRARY
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their plaque remains in this paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 85 18633	
1. DECEASED NAME (TYPE OR PRINT) George E. Ward, JR.						2a. DATE OF DEATH MONTH DAY YEAR 7 8 85			2b. HOUR 6 25 A M		
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 6 22		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS 6 25		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AAGH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEMAN FIRE			12b. BUSINESS OR INDUSTRY ARUNDEL CO.		
13a. STATE MARYLAND						13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE E. WARD, SR.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY E. TOWNSHEND					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ISABEL E. WARD		ADDRESS SAME AS 13E					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours	
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral heart failure										9 months	
DUE TO, OR AS A CONSEQUENCE OF (c) Acute myocardial infarction										17 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7 10 P.M. 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 7/10 , 19 85 , to 7/8 , 19 85 , that (I) (we) last saw the deceased alive on 7/7 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Gerard Rhoads M.D.						DEGREE			22c. DATE SIGNED SEVENTH MONTH 21 1985		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) GERARD RHODES						22c. ADDRESS 8 EMBLETON ROAD ANN 21146					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 7-11-85		23c. NAME OF CEMETERY OR CREMATORY ALL HALLOWS CHAPEL			23d. LOCATION CITY OR TOWN COUNTY STATE DAVIDSONVILLE A.A.CO.MD.			
24. FUNERAL DIRECTOR NAME ROBERT E. EVANS						1212 WEST STREET ADDRESS ANNAPOLIS, MARYLAND			25a. DATE REC'D. BY REGISTRAR JUL 22 1985		
						25b. REGISTRAR'S SIGNATURE John E. ...					

BP

001705

RECEIVED
MAY 10 1964



203448

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REC'D.

1 8 6 3 B4

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		
MYRTLE G WATKINS				JULY		15, 1985		11:45 AM		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female	White	MONTH DAY YEAR 5 15 03		82 YRS		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	U.S.A.				ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
GLEN BURNIE	NORTH ARUNDEL HOSPITAL			Parker		Glass Manufacturing				
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland					A.A.		Glen Burnie		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Gaylord Buckingham					FIRST MIDDLE LAST Lottie Unavailable					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO			217-09-0296		Wayne F. Watkins 8553 Dock Rd. 21122					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH.	
IMMEDIATE CAUSE (a) RESPIRATORY ARREST.									30 minutes	
DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EMBOLUS.										
Conditions, if any, which gave rise to immediate use (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
Lt. Hyp fracture										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
3/4/85		Repair of Lt. Hyp fract			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. TIME OF INJURY		21b. HOW INJURY OCCURRED			21c. LOCATION					
HOUR A.M. MONTH DAY YEAR P.M. 19		fall			CITY OR TOWN COUNTY STATE					
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. LOCATION								
Home		GLEN BURNIE, MARYLAND 21061								
22. I certify that (I) (this hospital) attended the deceased from 7/3, 1985, to 7/15, 1985, and that (I) (we) last saw the deceased alive on 7/15, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.										
22a. SIGNATURE					DEGREE		22c. DATE SIGNED			
Randy E. Davis					M.D.		7/15/85			
22b. PHYSICIAN'S NAME (TYPE OR PRINT)					22d. ADDRESS					
RANDY E. DAVIS, M.D.					200 HOSPITAL DRIVE, SUITE 409 GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION				
Burial		7/18/85		Meadowridge Mem. Pk.		CITY OR TOWN COUNTY STATE Elkridge Howard Maryland				
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR					
NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229					25b. REGISTRAR'S SIGNATURE JUL 17 1985					

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 above as any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in the funeral director's file. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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211505

218043

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NORA AGNES WELLS					2a. DATE OF DEATH MONTH DAY YEAR JULY 30, 1985		2b. HOUR A 10:55 M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 27 1913		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator		12b. KIND OF BUSINESS OR INDUSTRY Factory	
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Hanover		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1836 Simms Rd. 21076	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Broyles				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lulu Pearl Marecki					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 179-22-2038		17. INFORMANT ADDRESS Emma Reihl 1834 Simms Road 21076					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pancytopenia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Breast Cancer</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 weeks</u> <u>2 years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7-14</u> 19 <u>85</u> , to <u>7-30</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>7-14</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Long S. Hsu</u>				DEGREE M.D.				22c. DATE SIGNED 7-30-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LONG S. HSU, M.D.				22e. ADDRESS 7845 OAKWOOD ROAD, #104 GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 3, 1985		23c. NAME OF CEMETERY OR CREMATORY Crestlawn Garden Mem.		23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville Howard Maryland			
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.				ADDRESS 4107 Wilkens Avenue		25a. DATE REC'D. BY REGISTRAR AUG 2 1985		25b. REGISTRAR'S SIGNATURE <u>Gina Davidson</u>	

BP

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218015



RECEIVED
JUL 11 1964
U.S. AIR FORCE
HONOLULU, HAWAII



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1 8 6 3 6

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KATHERINE QUIGLEY WELSH			2a. DATE OF DEATH MONTH DAY YEAR July 8, 1985		2b. HOUR 212 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 1, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Arnold	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1600 Chickasaw Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Anne Arundel	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 570 Bellerive Dr. 21012	
14. FATHER'S NAME FIRST MIDDLE LAST John Quigley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hanna O'Harra		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (Daughter in-law) Mrs. Lois Welsh 1600 Chickasaw Rd. Arnold, Maryland	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cachexia of malignancy.

DUE TO, OR AS A CONSEQUENCE OF

(b)

Metastasis, lung, venous.

DUE TO, OR AS A CONSEQUENCE OF

(c)

Hyponephroma Right Kidney.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from May 21, 1985, to July 8, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE George P. Samaras		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/8/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 205 Ridgely Ave. Annapolis, MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE July 11, 1985	23c. NAME OF CEMETERY OR CREMATORY St. Luke Mt. Oliver Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Scott Township Pennsylvania
24. FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie, Md.		25a. DATE REC'D. BY REGISTRAR JUL 09 1985	
25b. REGISTRAR'S SIGNATURE John Davidson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____
DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

214010

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO. 8 18637

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT EUGENE WHITTINGTON				2a. DATE OF DEATH MONTH DAY YEAR 7 21 85		2b. HOUR 12³⁰ P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 29 32		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD	
10. CITY OR TOWN OF DEATH Crofton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Crofton Convalescent Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) D.C. Government	
13a. STATE MD				13b. COUNTY A.A.		13c. CITY OR TOWN Deale	
14. FATHER'S NAME FIRST MIDDLE LAST Perry Ambrose Whittington				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Knopp			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 1252-1254 215-32-1963		17. INFORMANT ADDRESS Alraro Whittington Deale, MD 20751	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) metastatic lung cancer DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) Indwelling Foley catheter and urinary tract infection. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from Jan 19 85 to 7/21 19 85 , that (I) (we) last saw the deceased alive on 7/15 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7/24/85		23c. NAME OF CEMETERY OR CREMATORY St. James Church	
24. FUNERAL DIRECTOR NAME Rausch Funeral Home				25a. DATE REC'D. BY REGISTRAR JUL 31 1985		25b. REGISTRAR'S SIGNATURE John Davidson	

1. The first part of the report is a summary of the work done during the year. It is a very brief summary, but it gives a good idea of the work done. It is a very brief summary, but it gives a good idea of the work done.

2. The second part of the report is a detailed account of the work done during the year. It is a very detailed account, but it gives a good idea of the work done. It is a very detailed account, but it gives a good idea of the work done.

3. The third part of the report is a summary of the work done during the year. It is a very brief summary, but it gives a good idea of the work done. It is a very brief summary, but it gives a good idea of the work done.

4. The fourth part of the report is a detailed account of the work done during the year. It is a very detailed account, but it gives a good idea of the work done. It is a very detailed account, but it gives a good idea of the work done.

5. The fifth part of the report is a summary of the work done during the year. It is a very brief summary, but it gives a good idea of the work done. It is a very brief summary, but it gives a good idea of the work done.

6. The sixth part of the report is a detailed account of the work done during the year. It is a very detailed account, but it gives a good idea of the work done. It is a very detailed account, but it gives a good idea of the work done.

7. The seventh part of the report is a summary of the work done during the year. It is a very brief summary, but it gives a good idea of the work done. It is a very brief summary, but it gives a good idea of the work done.

8. The eighth part of the report is a detailed account of the work done during the year. It is a very detailed account, but it gives a good idea of the work done. It is a very detailed account, but it gives a good idea of the work done.

9. The ninth part of the report is a summary of the work done during the year. It is a very brief summary, but it gives a good idea of the work done. It is a very brief summary, but it gives a good idea of the work done.

10. The tenth part of the report is a detailed account of the work done during the year. It is a very detailed account, but it gives a good idea of the work done. It is a very detailed account, but it gives a good idea of the work done.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO. 8 6 3 8

1- DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. DATE OF ESTI- MATED		2c. DATE OF DEATH		2d. HOUR	
Edward		Clark		Wilson				7 8 19 85		7 8 19 85		6:50P		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
Male	White	August 24, 1924		60						Anne Arundel County		Glen Burnie		North Arundel Hospital	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. NEVER MARRIED		10. WIDOWED		11. DIVORCED		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Virginia		United States		X								Consultant		Construction	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?	
Maryland		Baltimore		Baltimore		YES X NO		10 West Hamilton Street 21201		Walter		Beatrice		Yes	
17. FATHER'S NAME		17. MOTHER'S MAIDEN NAME		18. SOCIAL SECURITY NO.		19. INFORMANT		20. ADDRESS		21. WAS DECEASED EVER IN U.S. ARMED FORCES?		22. SOCIAL SECURITY NO.		23. INFORMANT	
Walter		Beatrice		219-12-4919		Mrs. Shirley H. Wilson		10 W. Hamilton Str		Yes		219-12-4919		Mrs. Shirley H. Wilson	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under-lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES X NO			
21a. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				5:33 P.M. 7 8 19 85				Pedestrian struck by auto							
21d. INJURY OCCURRED WHILE AT WORK X NOT WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
				road				I-695 & ramp to Rt. 295, Linthicum, A.A., MD.							
22. I certify that I took charge of the remains described above, held an Autopsy X Inspection Inquiry and in my opinion death resulted from: Natural causes Accident X Suicide Homicide Undetermined manner															
ACTUAL SIGNATURE				TITLE (SPECIFY)								DATE SIGNED			
Gregory R. Kauffman, M.D.				M.D. Assistant MEDICAL EXAMINER								7/9/85			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS								111 Penn St. Balto. MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Cremation				July 10, 1985				Greenmount Crematory				Baltimore			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Mitchell - wiedefeld Home				6500 York Road				JUL 12 1985				Gregory R. Kauffman			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 18. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

141



W. BOND
K. F. F. F.

RECEIVED
JUL 1 1968

JUL 1 1968

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1- FOR
STATE
REGISTRAR

85 REG. NO. 18639

1. DECEASED NAME (TYPE OR PRINT) CARL Alexander WIRTS			2a. DATE OF DEATH MONTH DAY YEAR 7 6 85			2b. HOUR 9:25 A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 7, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 83		7. IF UNDER 1 YEAR MONTHS DAYS YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co., MD.			
10. CITY OR TOWN OF DEATH Edgewater		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant Living Convalescent Ctr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Physician	
13a. STATE MD		13b. COUNTY A.A. Crownsville		13c. CITY OR TOWN 300 Kyle Road		13d. ZIP CODE 21032			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Wilmer Wirts				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie Kimmel				16. ADDRESS Same as #13	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR DATES) WWII 179-36-1468		17. INFORMANT Jessie Kyle Wirts - #13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Atherosclerotic Cardio-Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1985 , 19 7/6/85 , to 7/6/85 , 19 7/6/85 , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on 7/7/85 , 19 7/7/85 , and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I <input checked="" type="checkbox"/> did) (did not) view the body after death.									
22b. SIGNATURE Barry R. Nathanson				DEGREE DR. RICHARD PEECE ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7/6/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY R. NATHANSON				22e. ADDRESS 51 FRANKLIN ST. ANNAP, MD 21401					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE July 8, 1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG MD		
24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel - Annapolis, MD				25a. DATE REC'D. BY REGISTRAR JUL 16 1985		25b. REGISTRAR'S SIGNATURE J. W. MURPHY			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain portions. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

15/10/11

1. The first part of the report is a general
description of the area. It is a small
village with a population of about 100.
The main occupation is agriculture.
The soil is very fertile and the
climate is very good. The people are
very friendly and the atmosphere is
very pleasant. The village is very
well situated and the views are
very beautiful. The people are very
kind and the atmosphere is very
pleasant. The village is very well
situated and the views are very
beautiful. The people are very kind
and the atmosphere is very pleasant.

2. The second part of the report is a
description of the local economy. It is a
small village with a population of about
100. The main occupation is agriculture.
The soil is very fertile and the climate
is very good. The people are very
friendly and the atmosphere is very
pleasant. The village is very well
situated and the views are very
beautiful. The people are very kind
and the atmosphere is very pleasant.

3. The third part of the report is a
description of the local culture. It is a
small village with a population of about
100. The main occupation is agriculture.
The soil is very fertile and the climate
is very good. The people are very
friendly and the atmosphere is very
pleasant. The village is very well
situated and the views are very
beautiful. The people are very kind
and the atmosphere is very pleasant.

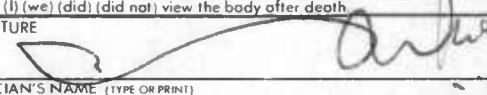
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO. 8 5 1 8 6 4 0

DECEASED NAME (TYPE OR PRINT) James C. Wood			2a. DATE OF DEATH MONTH DAY YEAR July 6, 1985		2b. HOUR 8:30am
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR February 23, 1903	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.		
10. CITY OR TOWN OF DEATH Odenton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kimbrough Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Service	12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE Md.	13b. COUNTY AA	13c. CITY OR TOWN Odenton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 491 Greenwood Street 21113	
14. FATHER'S NAME FIRST MIDDLE LAST Wood		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Hubbard			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW 2		16b. SOCIAL SECURITY NO. 216-22-2990	17. INFORMANT Beverly Wood, wife, same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interventricular cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ischemic</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		22c. DATE SIGNED JUL 8, 1985		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles J. Wu, M.D.	
22e. ADDRESS 7845 Oakwood Road, Glen Burnie		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8 July 85	23c. NAME OF CEMETERY OR CREMATORY Nichols Bethel Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Odenton, Anne Arundel, Md.		
24. FUNERAL DIRECTOR James S. Kirkley, Glen Burnie, Md.		25a. DATE REC'D. BY REGISTRAR JUL 9 1985			



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214147

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1 DECEASED NAME (TYPE OR PRINT) JAMES WORKMAN					2a. DATE OF DEATH MONTH DAY YEAR JULY 17, 1985 2b. HOUR 645 PM				
3. SEX MALE		4. RACE AFRO AMER		5. DATE OF BIRTH MONTH DAY YEAR 12 21 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INDIAN MAIN ENG.		12b. KIND OF BUSINESS OR INDUSTRY CLEANING	
13a. STATE MARYLAND 13b. COUNTY					13c. CITY OR TOWN MILLERSVILLE 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7 ZIP CODE 1211 LANDING RD. 21108		
14. FATHER'S NAME FIRST MIDDLE LAST REUBIN WORKMAN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES JUKNOW				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-07-1461		17. INFORMANT ADDRESS A HONORIA WORKMAN SAME AS ITEM 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral anoxia									
DUE TO, OR AS A CONSEQUENCE OF (b) respiratory arrest									
DUE TO, OR AS A CONSEQUENCE OF (c) chance of the lung									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) hypertension, malnutrition									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from April 8, 1985 to July 17, 1985 , that (I) (we) last saw the deceased alive on 7/17 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James J. Benjamin DEGREE MD					22c. ADDRESS 7300 RICHIE HIGHWAY GLEN BURNIE, MARYLAND 21061			22d. DATE SIGNED 7/18/85	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES J. BENJAMIN, M.D.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/20/85		23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEMORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND P.G. MD.			
24. FUNERAL DIRECTOR NAME ADDRESS MARSHALL'S FUNERAL HOME 4217 9TH ST. N.W. WASH, D.C.					25. DATE RECD. BY REGISTRAR 10/18/85		26. REGISTRAR'S SIGNATURE John Davidson		

ST 11415

POW. COLIC. FEBER

WID. 2

WID. 1



212062

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 186 42 EDT

1. DECEASED NAME (TYPE OR PRINT) ETHEL LEONA ZIMMERMAN			2a. DATE OF DEATH MONTH DAY YEAR JULY 26, 1985		2b. TIME OF DEATH HOURS MIN. 4:45 PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Jan. 04, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH HAVEN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Lumber Co.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY A. A. CO. 13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 40 Glendale Ave. 21061		
14. FATHER'S NAME FIRST MIDDLE LAST Leonard Graves		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Godwin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 220-14-1970	17. INFORMANT ADDRESS James J. Ridgell; 109 S. Longcross Rd. 21090			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE
DUE TO, OR AS A CONSEQUENCE OF (b) DISSEMINATED LUNG CANCER		3 months
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **NO**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7/15/85 , 19____, to 7/26/85 , 19____, that <input checked="" type="checkbox"/> (we) let saw the deceased alive on 7/26/85 , 19____, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE Duncan Salmon		DEGREE MD		22c. DATE SIGNED 7/27/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DUNCAN SALMON MD		22e. ADDRESS 660 KENILWORTH DR. TOWSON MD 21204			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 07/30/85	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.	23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard MD
24. FUNERAL DIRECTOR Hubbard Funeral Home; 4107 Wilkens Ave. 21229		25a. DATE REC'D. BY REGISTRAR JUL 29 1985	25b. REGISTRAR'S SIGNATURE Harold Davidson

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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RESPIRATORY ARREST
TERMINATED WITH CANCER



DAVID L. LAMON, M.D.
FACIAL CLINIC